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The Journal

of the

Michigan State Medical Society

Published under the Direction
of The Council

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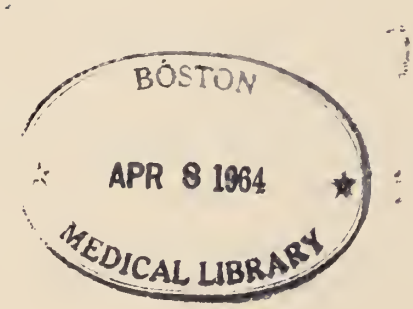
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1963

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the Journal
MICHIGAN
STATE MEDICAL SOCIETY
JANUARY 1963 • VOLUME 62 • NUMBER 1

"Blocks" permit selective

Pharmaceutical Lecture, March 13

Closed-circuit color television—teaching aid

ichigan Foundation for Medical Health Education Lecture, March 14

Surgery Block Wednesday morning, March 13

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registration fee for MSMS members

ractical hints waiting in the exhibits

Michigan Cancer Coordinating Committee Lecture, March 14

Sheraton-Cadillac—Michigan's Scientific Center, March 13-15

Trauma Block Wednesday afternoon, March 13

Evening Seminar on Geriatrics, March 14

Exhibits help provide facts and background

Clinical Roundtables open daily programs at 8:00 A.M.

ning Seminar on Mental Retardation, March 13

odern exhibits keep you up-to-date

levision beamed from U-M Hospital, 10:30 A.M., daily

Special program for medical students, interns, residents

Cardiovascular Block Thursday morning, March 14

Internal Medicine Block Thursday afternoon, March 14

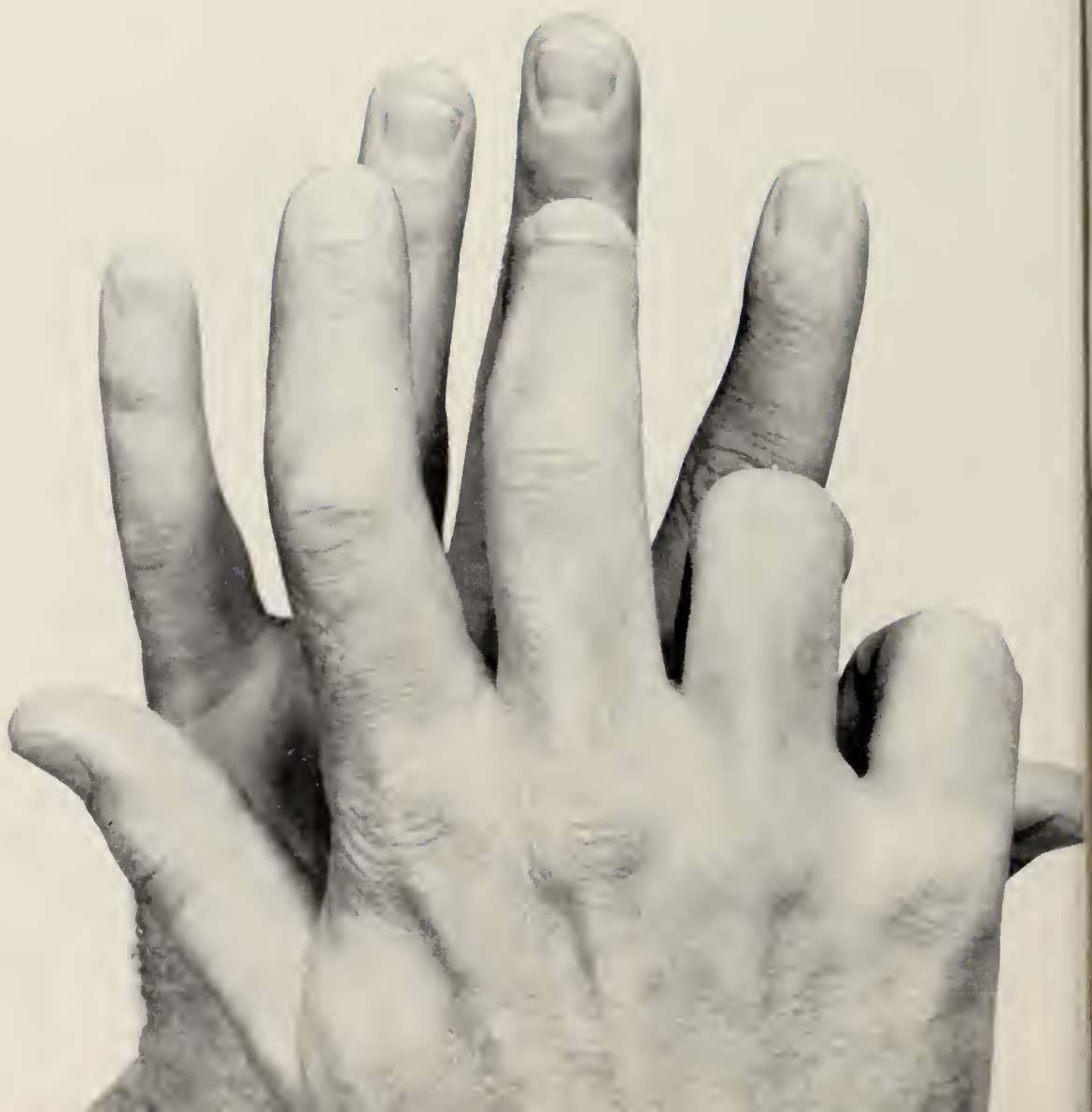
This number is composed of two sections, of which this is Section 1.

in severe respiratory infections
refractory to other measures

CHLOROMYCETIN

(chloramphenicol, Parke-Davis)

for established
clinical efficacy against
susceptible organisms[1]



In Friedlander's Pneumonia[3,13]

Although the prognosis in Friedlander's pneumonia is poor, treatment with CHLOROMYCETIN has shown a good response when susceptible strains of *Klebsiella pneumoniae* are incriminated.

In *Hemophilus Influenzae* Pneumonia[3,4,13,14]

Because the invading organism is usually sensitive to CHLOROMYCETIN, this agent is generally effective in pneumonias caused by *H. influenzae*.

In Staphylococcal Pneumonia[1-8,13]

CHLOROMYCETIN continues to remain effective against many resistant strains of staphylococci, and—alone or in combination with other antibiotics—should be considered when other antistaphylococcal drugs are ineffective.

In Acute Epiglottitis[4,10,11]

This condition is most often caused by *H. influenzae,* most strains of which are sensitive to CHLOROMYCETIN. Therapy should be instituted at once, since the disease may progress from the first symptoms to a severe respiratory obstruction in four to six hours.

In Pneumonias Due to Gram-negative Bacilli[9]

Because of its broad-spectrum activity, CHLOROMYCETIN is often effective in pneumonias caused by sensitive strains of *Aerobacter, Proteus* of various species, *Paracolobactrum,* and other gram-negative pathogens encountered with increasing frequency in serious respiratory tract infections.

In Staphylococcal Empyema[12]

The infiltrating lesions of staphylococcal empyema are often difficult to eradicate. While CHLOROMYCETIN should only be used when the infection has been resistant to treatment with other antistaphylococcal drugs, therapy with CHLOROMYCETIN, in conjunction with surgical procedures, will often bring favorable results.

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100. See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections such as colds, influenza, or viral infections of the throat, or as a prophylactic agent.

Precautions: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Thacher, H. C., & Fishman, L.: *J. Maine M. A.* **52**:84, 1961. (2) Hopkins, E. W.: *Postgrad. Med.* **29**:451, 1961. (3) Hall, W. H.: *M. Clin. North America* **43**:191, 1959. (4) Krugman, S.: *Pediat. Clin. North America* **8**:1199, 1961. (5) Ede, S.; Davis, G. M., & Holmes, F. H.: *J.A.M.A.* **170**:638, 1959. (6) Wolfsohn, A. W.: *Connecticut Med.* **22**:769, 1958. (7) Calvy, G. L.: *New England J. Med.* **259**:532, 1958. (8) Hendren, W. H., III, & Haggerty, R. J.: *J.A.M.A.* **168**:6, 1958. (9) Cutts, M.: *Rhode Island M. J.* **43**:388, 1960. (10) Berman, W. E., & Holtzman, A. E.: *California Med.* **92**:339, 1960. (11) Vetto, R. R.: *J.A.M.A.* **173**:990, 1960. (12) Sia, C. C. J., & Brainard, S. C.: *Hawaii M. J.* **17**:339, 1958. (13) Rosenthal, I. M.: *GP* **17**:77 (March) 1958. (14) Gaisford, W.: *Brit. M. J.* **1**:230, 1959.

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All communications relative to exchanges, books for review, manuscripts, should be addressed to Wilfrid Haughey, M.D., 610 Post Bldg., Battle Creek, Michigan.

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THE COVER

As in the past, the January number provides information about the Annual MCI. The cover design stresses the 1963 dates, and the diagonal lines each express a reason for participating. See you there!

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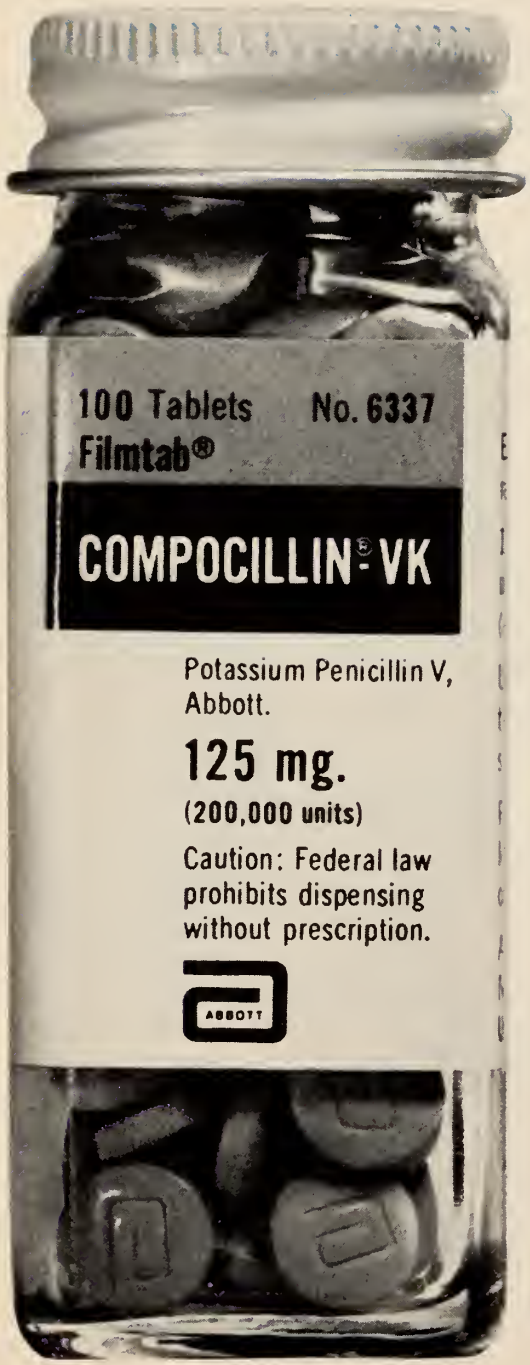
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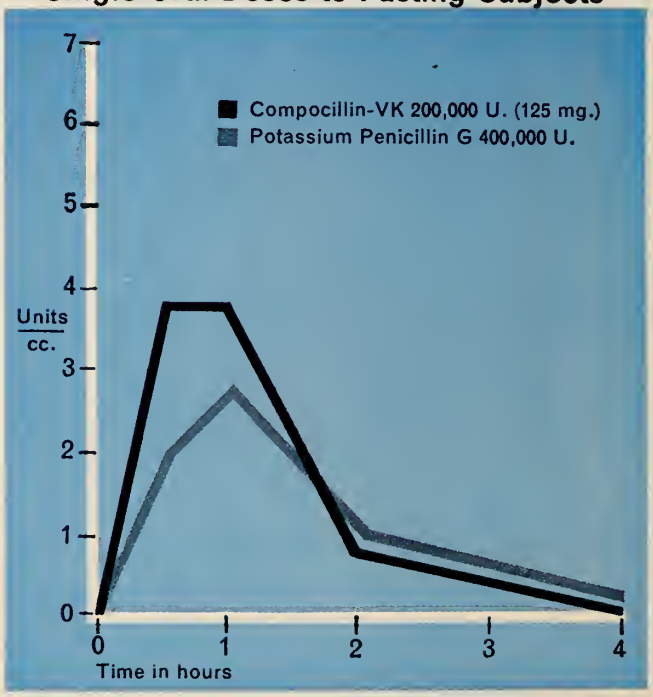
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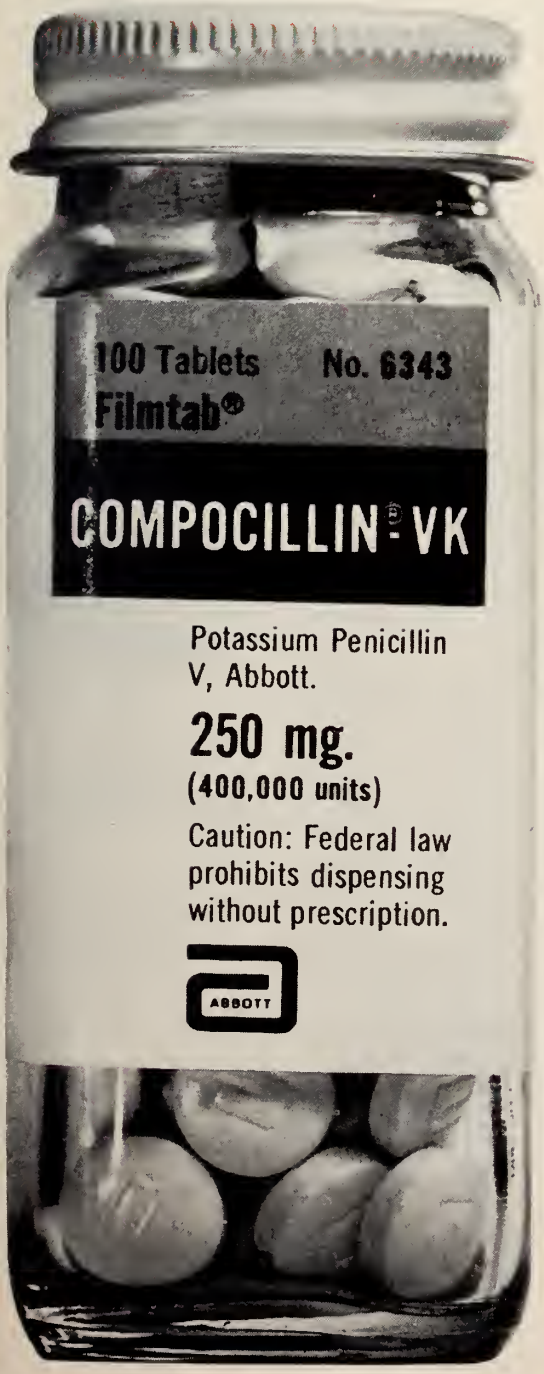
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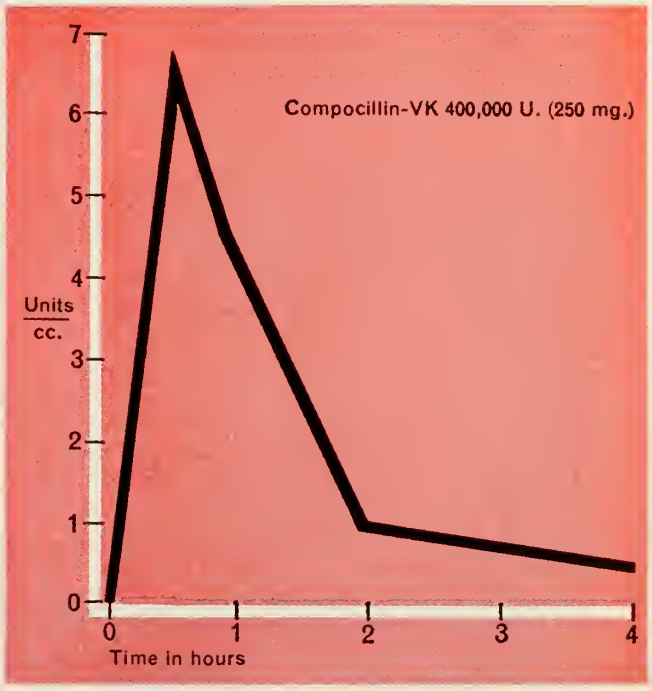
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President's Page

MIND-STRETCHING EXPERIENCE



C. I. Owen

Michigan State Medical Society

President

This number of "The Journal of MSMS" provides information about the excellent Michigan Clinical Institute coming up fast on our calendar.

And as we approach this excellent postgraduate opportunity (March 13-14-15 in Detroit), it is shocking to note that attendance across the nation is down at state society medical conferences.

Why is this so?

And need it continue?

Not too many years ago, such medical meetings as the Michigan Clinical Institute were eagerly anticipated as a major source of professional knowledge. We awaited the chance to confer about cases with former teachers and colleagues from other cities. Apparently, the doctor of medicine did not have many opportunities for such professional experiences.

True, some of the conditions today have changed. We are bombarded with literature, we are served by earnest detail men, the hospital staff meetings are helpful, and specialty group meetings are attractive inducements.

Some physicians endeavor today to participate in many of the medical conferences while others toss up their arms in despair and decide to attend none of them. The latter approach is professionally dangerous in these times of rapid medical advancements so we must all pick and choose which of the postgraduate events to attend.

The MCI, like the Annual Session, is *your* meeting. It is the finest "grass roots" medical program which can be developed. It will present a stimulating array of out-of-state and Michigan speakers and it will provide informative exhibits. While it's big enough to obtain the best possible speakers, it is small enough for you to be able to renew fellowships with former classmates and medical colleagues and school teachers.

Personally, I've always participated in the Michigan Clinical Institute, and I will in the future. I can assure you the 1963 MCI will be a mind-stretching experience. And I hope you agree that as members of the MSMS, we have a responsibility to support our own high-calibre MSMS postgraduate meetings. Right? See you in Detroit, March 13-14-15.

MCI Program to Offer Outstanding Medical Experts



The 1963 Michigan Clinical Institute will provide excellent opportunities for members of the Michigan State Medical Society to hear outstanding medical educators. Once again, the MCI will be held at the Sheraton-Cadillac Hotel in Detroit.

General Information

DATES —Wednesday, Thursday, Friday, March 13, 14, 15, 1963

HEADQUARTERS—Sheraton-Cadillac Hotel, Detroit

REGISTRATION —Fourth Floor, Sheraton-Cadillac Hotel

NO REGISTRATION FEE FOR MEMBERS OF MSMS AND OTHER STATE MEDICAL ASSOCIATIONS, AMA AND CANADIAN MEDICAL ASSOCIATION. Please have your membership card ready when you register.

EXHIBITS —Fourth Floor, Sheraton-Cadillac Hotel

INTERMISSIONS TO VIEW EXHIBITS —Wednesday, March 13: 10:00-10:30 a.m. and 3:00-4:00 p.m.

—Thursday, March 14: 10:00-10:30 a.m. and 3:00-4:00 p.m.

—Friday, March 15: 10:00-10:30 a.m. and 12:30-1:00 p.m.

NEWS ROOM —Michigan Room, Fifth Floor, Sheraton-Cadillac Hotel

TELEVISION —The closed-circuit, color television will be beamed from the University of Michigan Hospital. The programs will be aired at 10:30 a.m. each morning.

You Are Invited To Attend 1963 MCI

We do hope that you will plan today to attend the 1963 MCI. It will provide clinical roundtables, lectures, closed-circuit color television, ancillary group meetings—and the chance to renew old acquaintances.

Join us in Detroit, on March 13-14-15, won't you?

Sincerely,

GEORGE W. SLAGLE, M.D., *Chairman*

Committee on Arrangements

MCI Program

WEDNESDAY, MARCH 13

Clinical Round Tables—8:00 a.m. to 9:00 a.m.

No. I "Fractures"

Leader: Herbert E. Pedersen, M.D., Dearborn

Discussants: Benjamin W. Drompp, M.D., Little Rock, Ark.
Robert W. Bailey, M.D., Ann Arbor
Joseph L. Fleming, M.D., Detroit

No. II "Shock"

Leader: Alan P. Thal, M.D., Detroit

Discussants: Thomas M. Flake, M.D., Detroit
Peter L. McGee, M.D., Bay City
George D. Zuidema, M.D., Ann Arbor

No. III "Surgical Emergencies"

Leader: Wm. J. Fuller, M.D., Grand Rapids

Discussants: B. Elmore Henig, M.D., Grayling
Andres D. Resto, M.D., Eloise
Alexander J. Walt, M.D., Detroit

Assembly Program—9:00 a.m. to 5:00 p.m.

A.M. **Surgery Block**

9:00 "The Present Status of the Relation of Rectal and Colon Polyps to Cancer"
Neil W. Swinton, M.D., Boston, Massachusetts

9:30 "Diaphragmatic Hernia"
Donald B. Effler, M.D., Cleveland, Ohio

10:30 **Television Program**

"Examination and Treatment of Lesions of the Breast"
Robert C. Horn, Jr., M.D., Detroit
Richard O. Kraft, M.D., Ann Arbor
James W. Logie, M.D., Grand Rapids
Robert F. Powers, M.D., Saginaw
John N. Wolfe, M.D., Detroit
Leo W. Walker, M.D., Lansing

"Oh, My Aching Back"
Wayne W. Glas, M.D., Eloise
Richard C. Schneider, M.D., Ann Arbor
Robert W. Bailey, M.D., Ann Arbor
Albert W. Farley, M.D., Saginaw
Carl F. List, M.D., Grand Rapids
Stanley Olejniczak, M.D., Eloise

P.M. **Trauma Block**

1:30 "Treatment of Head Injuries"
Elisha S. Gurdjian, M.D., Detroit

2:00 "Amputation and Prosthesis"
Newton C. McCollough, M.D., Orlando, Florida

4:00 "Treatment of Injuries of the Cervical Spine"
Benjamin W. Drompp, M.D., Little Rock, Arkansas

4:30 **Pharmaceutical Lecture**

"The Dawn of a New Era"
Theodore G. Klumpp, M.D., New York City

8:00 **Public Meeting**

"Why Mental Retardation"
Chairman: Jacques S. Gottlieb, M.D., Detroit
Panelists: John A. Churchill, M.D., Detroit
on "Physical Environmental Factors"
Hilda R. Knobloch, M.D., Columbus, Ohio
on "Socio-Cultural Factors"
John H. Menkes, M.D., Baltimore, Maryland
on "Genetic Metabolic Factors"

THURSDAY, MARCH 14

Clinical Round Tables—8:00 a.m. to 9:00 a.m.

No. IV "Equipment and Drugs in Cardiac Arrest"

Leader: Larry H. Birch, M.D., Grand Rapids

Discussants: James R. Jude, M.D., Baltimore, Maryland
Herbert E. Sloan, M.D., Ann Arbor
Vernon E. Wendt, M.D., Detroit

No. V "Place of Regional Perfusion in Cancer"

Leader: Vainutis K. Vaitkevicius, M.D., Detroit

Discussants: Robert W. Talley, M.D., Detroit
John N. Wolfe, M.D., Detroit

No. VI "The Rational Use and Tragic Abuse of the Tranquilizers and Energizers"

Leader: Jacques S. Gottlieb, M.D., Detroit

Discussants: Peter G. S. Beckett, M.D., Detroit
Elliot D. Luby, M.D., Detroit

Assembly Program—9:00 a.m. to 5:00 p.m.

A.M. **Cardiovascular Block**

9:00 Panel on "Cardio-Pulmonary Resuscitation"
Chairman: Larry H. Birch, M.D., Grand Rapids
Panelists: James R. Jude, M.D., Baltimore, Maryland
Herbert E. Sloan, M.D., Ann Arbor
Vernon E. Wendt, M.D., Detroit

10:30 **Television Program**

"Management of Goiter"
Nelson M. Taylor, M.D., Grosse Pointe
Harry A. Towsley, M.D., Ann Arbor
Josip Matovinovic, M.D., Ann Arbor
Robert E. Mack, M.D., Detroit
Marion S. DeWeese, M.D., Ann Arbor
Frederick A. Coller, M.D., Ann Arbor
Alexander J. Walt, M.D., Detroit
Myer Teitelbaum, M.D., Detroit
Robert C. Douglass, M.D., Farmington
John Batsakis, M.D., Ann Arbor
Brock E. Brush, M.D., Detroit
George H. Lowrey, M.D., Ann Arbor
J. Martin Miller, M.D., Detroit
James W. Landers, M.D., Detroit
Seymour A. Vander, M.D., Detroit

P.M. **Internal Medicine and Cancer Block**

1:30 "Care of the Patient with Chronic Failing Kidney"
Ivan J. Mader, M.D., Huntington Woods

2:00 "Patho-Physiology of Acute Pancreatitis"
David A. Dreiling, M.D., New York, N. Y.

2:30 Panel on "Pancreatitis"
Chairman: David A. Dreiling, M.D., New York, N. Y.
Panelists: Wm. S. Haubrich, M.D., Detroit
Alfred M. Large, M.D., Detroit
H. Marvin Pollard, M.D., Ann Arbor
Alan P. Thal, M.D., Detroit

4:00 **Michigan Foundation for Medical and Health Education, Inc., Lecture**

"Intestinal Obstruction"
Philip Thorek, M.D., Chicago, Illinois

4:30 **Michigan Cancer Coordinating Committee Lecture**

"The Prevention of Cancer by Surgical Means"
Jonathan E. Rhoads, M.D., Philadelphia, Pennsylvania

8:00 **Public Meeting**

"Health Problems of the Aging American"
Moderator: A. Hazen Price, M.D., Detroit
"Major Medical Problems of Older People"
Edward E. Henderson, M.D., Montclair, New Jersey
"Why Surgery Is Sometimes Necessary in the Care of Older People"
Brock E. Brush, M.D., Detroit

FRIDAY, MARCH 15

Clinical Round Tables—8:00 a.m. to 9:00 a.m.

No. VII "Pediatrics"

Leader: *Jack H. Hertzler*, M.D., Detroit
Discussants: *Robert D. Allaben, M.D.*, Detroit
Waldo L. Cain, M.D., Detroit
John P. Harm, M.D., Detroit
Ruben Meyer, M.D., Detroit

No. VIII "Obstetrics—Current Problems"

Leader: *Joseph H. Curhan, M.D.*, Detroit
Discussants: *Wm. W. Jack, M.D.*, Grand Rapids
Russell R. deAlvarez, M.D., Seattle, Washington
Charles A. Behney, M.D., Lansing

No. IX "Gynecology—Current Problems"

Leader: *Palmer E. Sutton, M.D.*, Birmingham
Discussants: *C. Paul Hodkinson, M.D.*, Detroit
Wm. F. Goins, M.D., Detroit
Joseph Sternberg, M.D., Montreal, Quebec

Assembly Program—9:00 a.m. to 5:00 p.m.

A.M. **Obstetrics-Gynecology Block**

9:00 "Uterine Curettage—Some Pitfalls and Sequelae"
Harold C. Mack, M.D., Detroit

9:20 (subject to be announced)
Russell R. deAlvarez, M.D., Seattle, Washington

9:40 "Placental Transmission"
Joseph Sternberg, M.D., Montreal, Quebec

10:30 **Television Program**

"*In Situ* Carcinoma of the Cervix"

Norman F. Miller, M.D., Ann Arbor
Samuel J. Behrman, M.D., Ann Arbor
T. N. Evans, M.D., Ann Arbor
Millard J. Albers, M.D., Saginaw
James H. Beaton, M.D., Grand Rapids
C. Paul Hodgkinson, M.D., Detroit
Murray R. Abell, M.D., Ann Arbor
Rosser L. Mainwaring, M.D., Dearborn

"Examination of the Newborn"

Paul V. Woolley, M.D., Detroit
Frederico A. Arcari, M.D., Detroit
Robert H. Gregg, M.D., Detroit
Wyman C. C. Cole, Jr., M.D., Detroit

Meetings of Ancillary Groups

The Michigan Proctologic Society will meet for cocktails and a dinner-meeting on Wednesday, March 13.

The Michigan Chapter Committee on Trauma, American College of Surgeons will meet at 12:00 noon (luncheon-meeting) on Wednesday, March 13.

The Michigan Epilepsy Center and Association will hold a 7:30 p.m. meeting on Wednesday, March 13.

The Michigan Society of Neurology and Psychiatry and the Michigan District Branch of the American Psychiatric Association will meet on Thursday, March 14, as follows:

P.M.
4:00 Council Meeting
4:30 Panel on "Elements of the Supernatural and Diabolical"
Garfield Tourney, M.D., Associate Professor of Psychiatry, Wayne State University College of Medicine
Alexander Dukay, M.D., Assistant Superintendent, Ypsilanti State Hospital
6:00 Cocktails
7:00 Dinner
8:00 Scientific Program—open to all physicians
"Suicide in General Practice and in Psychiatry"
Kenneth Pitts, M.D., Assistant Professor of Psychiatry, Wayne State University College of Medicine
Viggo W. Jensen, M.D., Clinical Associate Professor of Psychiatry, Wayne State University College of Medicine
Henry G. Chall, M.D., Detroit
Douglas A. Sargent, M.D., Clinical Associate Professor of Psychiatry, Wayne State University College of Medicine

The Wayne State University College of Medicine will maintain headquarters in the Sheraton-Cadillac Hotel, during the Michigan Clinical Institute. All alumni, their guests, and friends of Wayne State University are cordially invited to visit the headquarters. The room location will be posted at the registration desk.

HOSPITAL STATISTICS

Cost Figures Reported

It cost patients $33.91 per day, on the average, to stay in the nation's general hospitals last year—and it cost the hospitals $36.04 per day to keep and care for them. The difference of $2.13 per patient day came from contributions and grants.

According to the American Hospital Association, patients paid a total of $4,314,000,000 to general hospitals in 1961. To all hospitals they paid $6,407,000,000.

Fifty-eight per cent of the latter amount, or $3,687,000,000 was paid by health insurance benefits.

Women Employees

Four out of every five hospital employees are women.

A total of 950,800 women were employed in April, 1962 in hospitals, representing 81 per cent of the total employment, according to the U. S. Department of Labor. Twelve months earlier there were 33,000 fewer women working in hospitals.

HIGHLIGHTS of The Council

Meeting of November 14, 1962

Eighty-two items were presented to The Council at its November meeting in the MSMS headquarters, East Lansing. Chief of importance were:

- Financial report. Chairman W. W. Babcock, M.D., of Detroit presented financial status of the Society to October 31, including financial report on 1962 Annual Session (including State Society Dinner-Dance of September 27). Doctor Babcock also reported on two meetings of the Finance Committee, September 23 and November 14. At the latter, the Committee recommended the development of a Health Fair in Cobo Hall, Detroit, in connection with the 1965 MSMS Centennial, with the discontinuance of State Fair participation by MSMS during the years 1963-1964-1965. (Action on this proposal was postponed for consideration at the December meeting of The Council).

 Bills payable for the month were presented, approved, and ordered paid.

- Other Committee reports:

 (a) Cardiac Disease Control Committee, meeting of September 12 reviewed the Committee's deliberation on the distribution of Cardiac Disease and Rheumatic Fever Desk Reference Cards and the possibility of developing cards on coronary heart disease; also the possibility of improving utilization of the cardiac disease speakers' bureau.

 (b) State Fair Committee, meeting of September 12 appraised the 1962 State Fair MSMS Exhibit and participation in future State Fairs (these minutes were referred to the Finance Committee for study in conjunction with recommendation re Health Fair at 1965 Centennial).

 (c) Liaison Committee with Michigan Association of Osteopathic Physicians and Surgeons, Inc. Chairman John J. Coury, M.D., of Port Huron reported on recent meeting with representatives of the Osteopathic Association.

 (d) Rehabilitation Committee, meeting of September 26, contained a report on results of survey of current component society rehabilitation committees, consideration of steps to obtain information on rehabilitation services in Michigan, and a discussion of rehabilitation activities of Michigan Department of Health.

 (e) Centennial Committee, September 27. This Committee, composed of MSMS Past Presidents, recommended projects for the Centennial of 1965, including sponsorship of a Health Fair in Cobo Hall (referred to Finance Committee). Executive Director Wm. J. Burns was named Coordinator of the MSMS Centennial.

 (f) MSMS Committee Organization, October 3, reviewed presentations made to Chairmen of MSMS Committees covering individual committee purposes, policies, general principles, and other items of specific interest to Committee Chairmen in their organizational work.

 (g) Cancer Control Committee, October 4, discussed uniform method of reporting positive and negative cytology smears, review of the operation of the Michigan Cancer Registry, and approval for development of a booklet on how to do cytology test.

 (h) Iodized Salt Committee, October 4, reviewed progress in formulating plans for a film on iodized salt, results of a salt utilization survey, and final plans for a restudy of soil and water samples from four selected counties in Michigan.

 (i) Committee on Alcoholism and Drug Addiction, October 11, reviewed action of 1962 House of Delegates, progress on the MSMS Journal Alcoholism Number, current activities throughout Michigan, and a proposed conference with the Michigan State Pharmaceutical Association re paregoric and other drugs.

 (j) Ethics Committee, October 11, considered an appeal from an expulsion order from a component Society (The Council approved the minutes and thereby affirmed the MSMS Committee on Ethics action on expulsion).

 (k) Minutes of Section Officers' meeting, October 17, contained recommendations and suggestions for the 1963 Annual Session program, selection of assembly officers, and programs of sections.

 (l) 1963 Annual Session Committee on Arrangements and Program, October 17, reviewed Annual Session pattern, suggestions for Assembly program received from section officers, and preliminary development of this program.

 (m) Committee to Study Prevention of Highway Accidents, October 25, covered a report from the State Safety Commission, contained a recommendation that through a regular Society mailing to MSMS members seatbelts be offered at a substantial saving

(Continued on Page 16)



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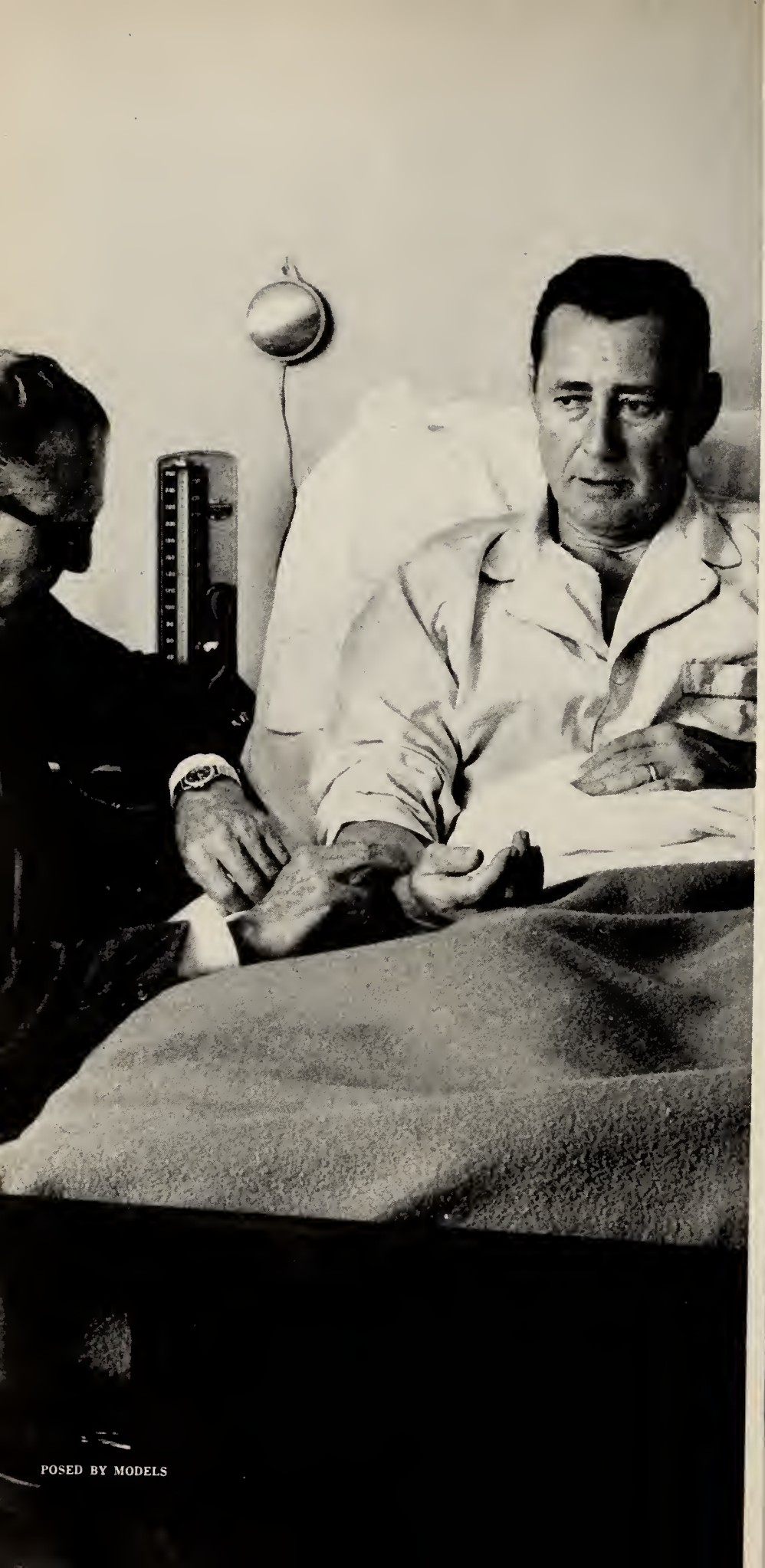
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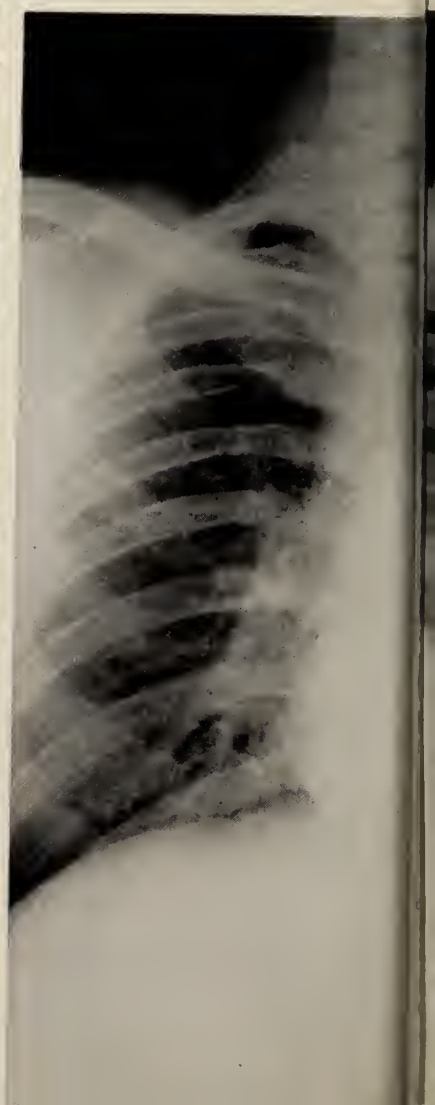
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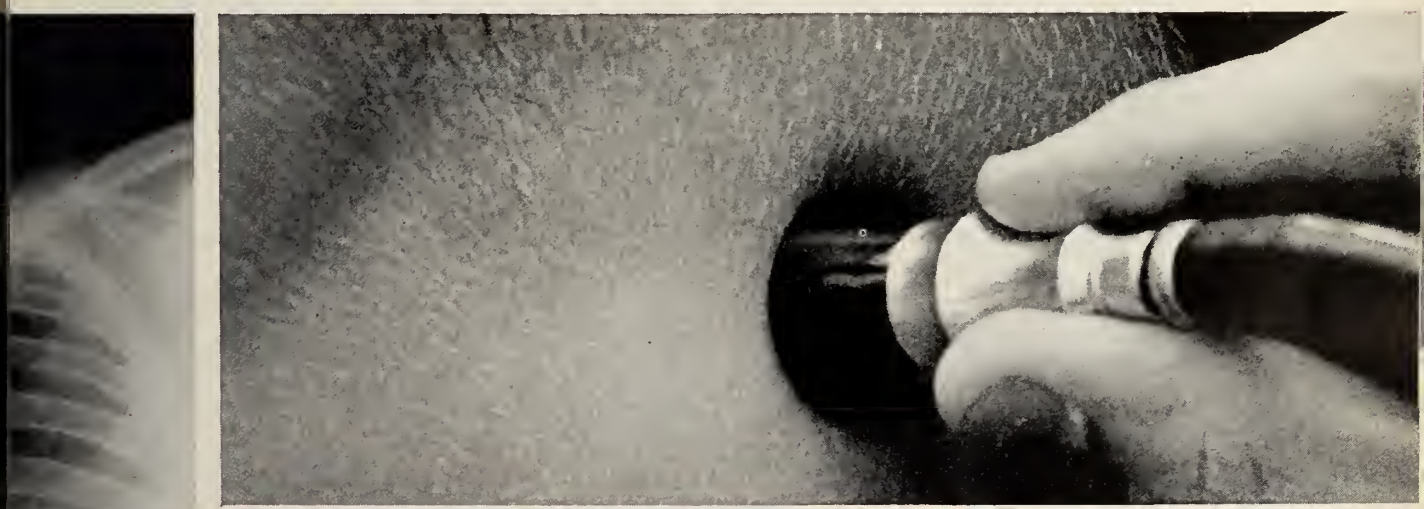
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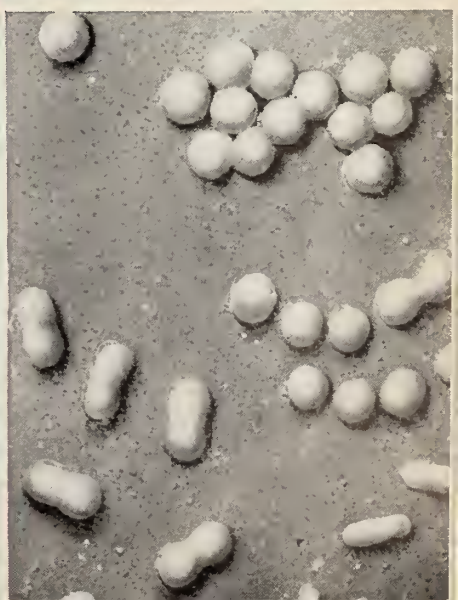
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Highlights of The Council Meeting

(Continued from Page 12)

so that physicians by personal example may encourage wider use of these safety devices, and recommended that The MSMS Council express endorsement of State legislation making the installation of seatbelts mandatory in all driver training vehicles in Michigan. (Approving these minutes, The Council stressed that this is not to be construed as an endorsement of any particular make of seatbelts.)

(n) Medical Socio-Economic Committee, October 29, discussed the Kalamazoo study of medical care, the University of Michigan research program entitled "Evaluation of Public Health Practices," and a description of the pilot workshop planned for Oakland County.

(o) Committee on Courses on Medical Economics and Ethics, August 12, reviewed the 22 topics which speakers presented to the senior medical students during the 1961-62 scholastic year at U-M, and contained suggestions for the 1962-63 program.

(p) Mental Health Committee, October 30, reviewed report of the AMA Congress on Mental Illness and Health, and report of the Steering Committee of the Michigan Delegation to this Congress. The Committee recommended that it set up an ad hoc subcommittee to study significant areas of mental health for the purpose of developing and carrying out a program of improving mental health in Michigan.

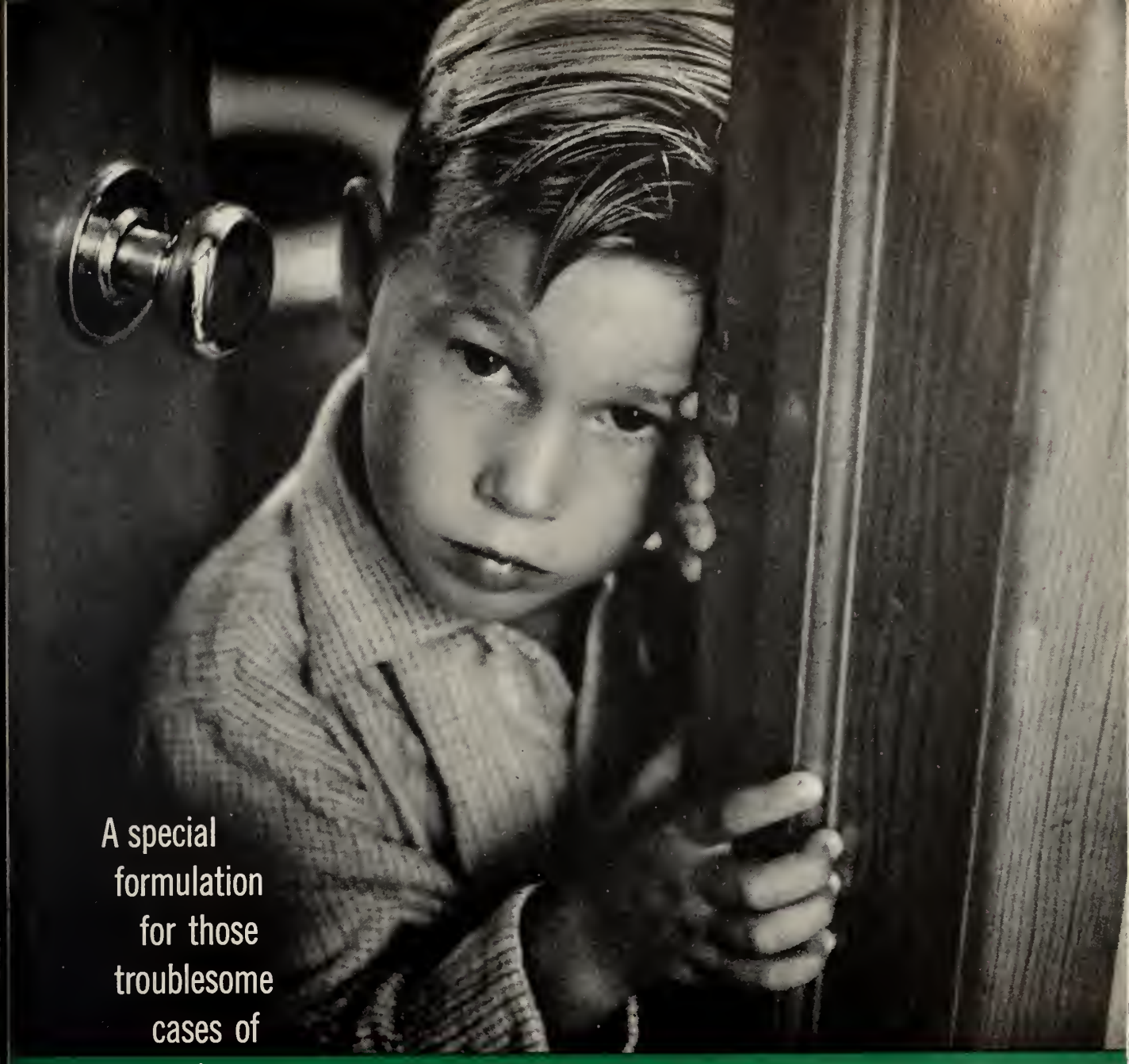
(q) Liaison Committee with Michigan State Nurses Association, August 29 (a Committee to which MSMS sends representatives): The Committee discussed purposes of the Committee as (1) interpret the professional goals of nursing, (2) interpret the role of nursing in patient care, (3) explore and identify traditional practices, (4) explore influence of some members of medical profession on education of nurses.

(r) Michigan Cancer Coordinating Committee, October 4 (a Committee to which MSMS sends representatives): The minutes contained financial report, report on Moscow Cancer Conference, progress report of subcommittees, cancer quackery exhibit, cancer comment page in JMSMS, preparation of booklet re cytology program, and selection of MCCC Lecturer at 1963 Michigan Clinical Institute.

(s) Public Relations Committee minutes of September 5, explained by Chairman R. W. Teed, M.D., of Ann Arbor, including report on 1962 State Fair exhibit, recommendation that two representatives be sent to Albany, New York, to review proposed two-way radio medical education network, the 1962 "Get Out the Vote" campaign, recommendation that a subcommittee be appointed to meet with the Geriatrics Committee to develop programs for the effective use of senior citizens, proposed meetings with newspaper editors in various areas of the State, and recommendation that an emergency aid station in the State Capitol building during 1962 legislative session be supported by MSMS. The minutes also reported suggestions for printing a standard pamphlet regarding use and operation of Kerr-Mills for adaption for county use, that a newspaper health column be made available on a trial basis to medical societies, and finally, that journalistic seniors, university pre-med clubs and economic majors be invited, as a pilot project to visit MSMS headquarters and hold discussions with MSMS leaders (The Council thanked Doctor Teed for coming to Lansing to discuss these important matters with The Council).

- The Advisory Committee to the Executive Director, through Chairman C. I. Owen, M.D., of Detroit, reported on its November 13 meeting. Highlights included discussion of neglect in renewal of state narcotics license (52 MSMS members have not obtained their 1962 license); refinement of members' history cards (IBM); hospital licensing bills; duties of the Secretary and Executive Director.
- Michigan Medical Service. Up-to-date information and discussion of matters of mutual interest were presented by Michigan Medical Service President Sidney Adler, M.D., of Detroit.
- President C. I. Owen, M.D., announced additional appointments to committees; request for MSMS representatives to Michigan Congress of Parents and Teachers (Robert M. Heavenrich, M.D., of Saginaw was appointed); report on November 10 Seminar in Kalamazoo on Kalamazoo Health Care Study.
- President-Elect Orlen J. Johnson, M.D., reported invitation from American Hospital Association for MSMS representatives to attend Regional Working Conference in Chicago, December 3-7, (Otto K. Engelke, M.D., of Ann Arbor was appointed); request to MSMS to join Michigan's Citizens Council on Agricultural Labor; and progress report on AMA-ERF.
- Council Chairman O. B. McGillicuddy, M.D., presented personnel of Committees of The Council for the Society year 1962-63; he appointed MSMS representatives to attend three meetings; he urged support of expansion of Blue Cross-Blue Shield Member Councils in various Michigan communities, which was approved; he appointed Carl B. Beeman, M.D., of Grand Rapids as General Chairman of Arrangements for 1963 Annual Session; he announced that Don W. McLean, M.D., Detroit and

(Continued on Page 22)



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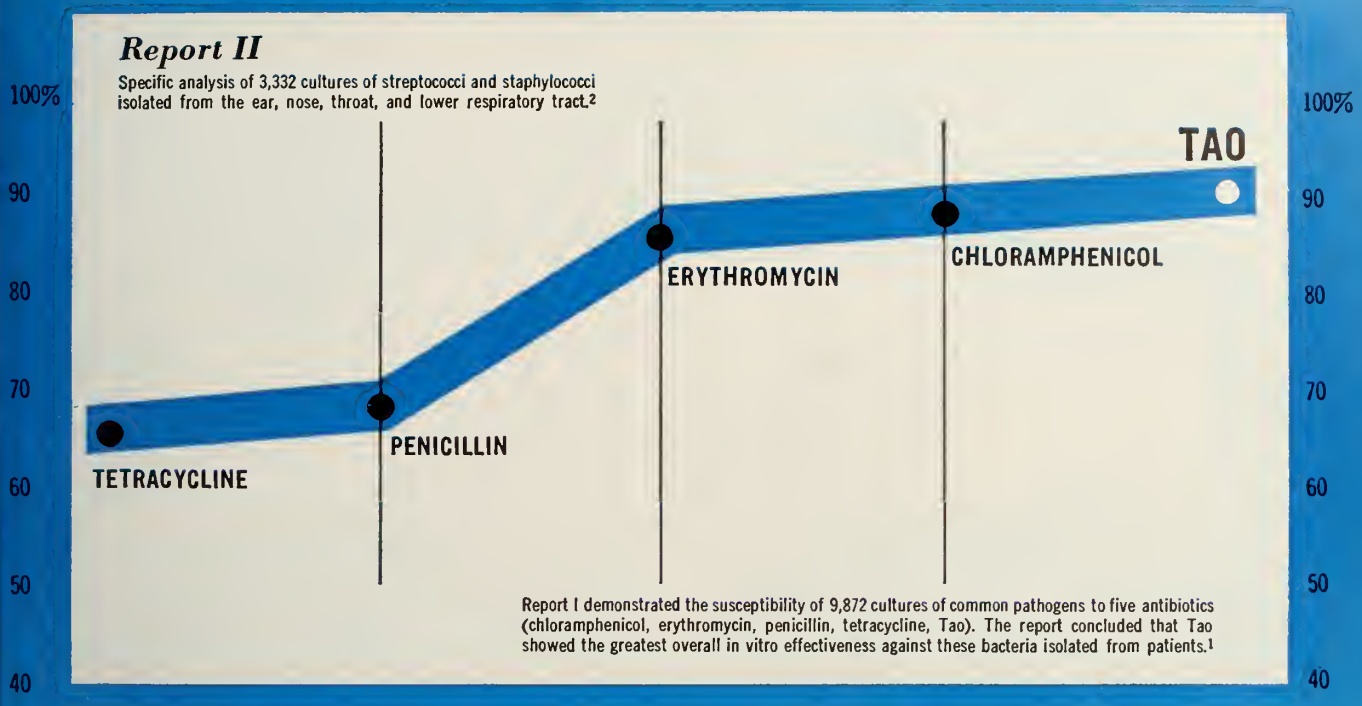
FROM A NATIONWIDE SURVEY OF 9,872 CULTURES OF COMMON PATHOGENS[1]

Conclusions of Nationwide Survey: *Report I*

1. **Even after five years of general use,** Tao, of the antibiotics tested, demonstrated greatest activity against respiratory streptococci and staphylococci (3,332 cultures).

2. **Overall results showed a higher percentage of susceptibility** among these common pathogens to Tao than to the other antibiotics. Susceptibility to Tao was greatest, not only in respiratory streptococci and staphylococci, but also in these organisms isolated from skin and soft tissue (3,423 cultures), genitourinary and gastrointestinal tracts and other sources (2,458 cultures). Susceptibility was equal to all antibiotics tested in pneumococci from unspecified sources (463 cultures), and less to Tao in H. influenzae from unspecified sources (196 cultures).

3. **Tao has been used for five years without development of predictable cross resistance.** In 1958 and 1961, approximately 73% and 70%, respectively, of erythromycin-resistant problem staphylococci showed susceptibility to Tao.[3,4] The present study confirms the continuing high degree of Tao activity even against these pathogens. Of 1,592 cultures of erythromycin-resistant staphylococci, 68% were susceptible to Tao, while in the reverse situation, only 33% of 768 Tao-resistant staphylococci were susceptible to erythromycin.



Report II

Results of Bacterial Susceptibility in 3,332 Respiratory Pathogens

References

1. "Bacterial Susceptibility Patterns: A Geographic Survey." Fowler, J. Ralph, M.D., and Watters, John L., M.D. Scientific Exhibit presented at the Annual Meeting of the American Society of Clinical Pathologists, Chicago, Ill., August 31 to September 9, 1962. 2. Fowler, J. Ralph, Watters, John L. and Levy, Arthur M.: Bacterial Susceptibility Patterns as Related to Geographic Variation and Anatomical Source. In press. 3. English, A. R., and Fink, F. C.: Antibiot. & Chemother. 8:420 (Aug.) 1958. 4. English, A. R., and Fink, F. C.: Antibiot. and Chemother. 11:648 (Oct.) 1961.

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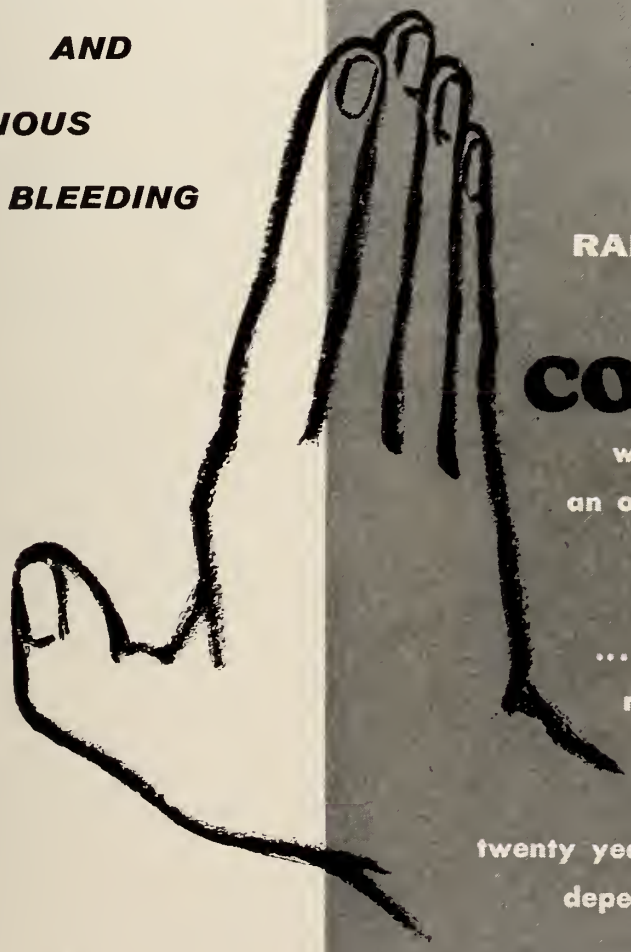
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Highlights of The Council Meeting

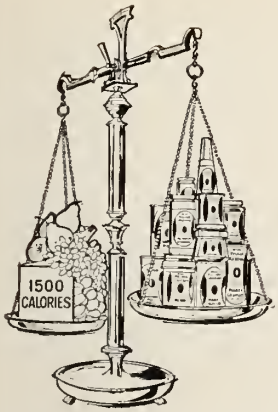
(Continued from Page 16)

H. W. Harris, M.D., Lansing as advisors to the Michigan Crippled Children Commission on revision of MCCC fee schedules; that Otto K. Engelke, M.D., had been appointed MSMS representative to attend meetings of Michigan Hospital Association Legislative Committee; at the Council Chairman's suggestion, an ad hoc committee was appointed to review policies of The Council with a view to indexing and publishing important actions of that body (Committee: H. H. Hiscock, M.D., R. V. Daugharty, M.D., and C. Allen Payne, M.D.); The Council Chairman was authorized to appoint three MSMS representatives to a Liaison Committee with the Michigan State Pharmaceutical Association.

- Secretary D. Bruce Wiley, M.D., reviewed 1962 House of Delegates action on study of component society bylaws; reported on meeting with Michigan State Board of Registration in Medicine held October 11 (attended also by President Owen) to discuss recognition of M.D.s certified by the National Board of Medical Examiners for license to practice medicine in the State of Michigan; and request from Association of American Medical Colleges for MSMS representative to attend its December 9 meeting (J. W. Rice, M.D., was appointed).
- Legal Counsel Dodd presented opinions on (a) consent to autopsy, (b) applicability of Workmen's Compensation Act to employee nurse, (c) power of a component society to fix dues, and (d) optician litigation.
- Executive Director Wm. J. Burns' report included staff coverage of 20 committee meetings and 47 other meetings of component societies and ancillary groups; plans for the 1963 MSMS Annual Session in Grand Rapids and for the Centennial of 1965 in Detroit; workshop in MSMS building for staff held October 10; semi-annual workshop for Michigan's component society executive secretaries held at MSMS headquarters on November 8; schedule of current "State Society Nights" arranged by 5 component societies; progress of the 1963 Michigan Clinical Institute program; and report on mailings (a total of 68,314 pieces).
- Public Relations Counsel Hugh W. Brenneman reported on recent election results of interest to physicians, and the handling of publicity surrounding recent debate in Wayne County on "The Role of Government in Health Care."
- Building Advisor Kenneth H. Johnson, M.D., of Lansing reported on new maintenance arrangement for the building and on the present condition of the headquarters.
- County Societies Committee Chairman R. J. Mason, M.D., of Birmingham presented proposed plans for the 1963 County Secretaries-Public Relations Seminar scheduled for January 24, 1963 in Lansing.
- Members of The Council presented the following matters: (a) Doctor Mason reported on a pilot workshop on medical socio-economics to be held in Oakland County in December sponsored by the MSMS Research Department and Oakland County Medical Society; (b) Doctor Rice reported on alternate plan for disaster medical care to serve in interim between disaster impact and time the state disaster plan can get into operation; (c) Doctor LeFevre reported on a hospital staff problem in his District: certain MSMS officers were authorized to attend a State Society Night program in this particular county to help solve the problem.
- Meeting with Michigan Hospital Association Board. Matters of mutual interest were discussed at a luncheon-meeting, held in MSMS headquarters, with the Board of Directors of the Michigan Hospital Association, including consideration of hospital licensing bills.
- Speaker J. J. Lightbody, M.D., of Detroit reported on actions taken by 1962 House of Delegates of special interest to the MSMS Council including Resolution Number 11 re proposed changes in Kerr-Mills Law (referred to committees for report to The Council by December 12); Resolution No. 8 re evaluation of non-hospital medical care (referred to Public Health Committee); Resolution No. 16 re single medical practice act (referred to Legal Affairs Committee); Resolution No. 19 re Function of Public Health Service (referred to Public Health Committee); Resolution No. 22 re change in duties of MSMS Secretary and Executive Director (already referred to a committee to study and report at Annual Meeting of The Council, January, 1963); Resolution No. 30 re Health Insurance Pooling (referred to Legal Affairs Committee); Resolution No. 50 opposing health care advisory committee to State Insurance Commissioner (referred to staff to implement); Resolution No. 59 re Unemployment and Workmen's Compensation Acts (referred to Occupational Medicine Committee); Resolution No. 60 re Consolidation of State Health Agencies (referred to a study committee); Resolution No. 61 re Driver-Operator License (referred to a committee to be appointed by the President); Resolution No. 2 re New Poll on Social Security (to be sent to all members with December President's Letter).

Report of Committee to Study Problem of Indigent or Ill Physicians (referred to a permanent

(Continued on Page 24)



How to get patients to follow your directions for weight control...easily

60 DELICIOUS FOODS THAT CUT CALORIES, FAT AND CARBOHYDRATES!

How often do you sit across the desk from a patient whose problem is overweight, and wonder whether the directions you give for diet will be followed accurately—or at all?

A pleasant and efficient solution to this problem is to recommend the new Mott's Figure Control Foods. This line of over 60 different items has been developed through the latest scientific knowledge in the field of nutrition—and provides foods lower in calories by an average of 50%. Figure Control Foods take the guesswork out of menu-planning. Calorie cutting can be made pleasant and accurate, while eating normal-size portions of the kinds of food people enjoy every day at breakfast, lunch and dinner.

Low carbohydrate, low fat: Meat products have most of the hard fats removed (these are the saturated type) in a way that cannot be done at home. Sauces and dressings are prepared with a high proportion of non-fat milk solids, vegetable colloids; all are delicious and appetizing. Fruits, juices, desserts and sauces are prepared with non-caloric sweetener—natural fruit values are intact.

The carbohydrate, protein and fat content appears on each label, along with calorie counts. Useful for diabetics, too.

Easy medical tool for doctors: No possible dangerous side effects, not even temporary dislocation of meal patterns. Figure Control Foods in supermarkets include: Soups, Meats, Poultry, Sauces, Salad Dressings, Preserves, Syrup, Fruits, Drinks, Desserts, Sweeteners.

New Mott's Figure Control® Foods offer Good Eating at Half the Usual Calories

	Quantity	Figure Control Calories	"Regular" Food Calories
Apple-Grape Drink	½ cup	20	52
Five-Fruit Juice Breakfast Drink	½ cup	20	52
Braised Beef and Vegetables	6½ oz.	184	380
Meat Balls in Brown Gravy	3½ oz.	84	280
Chopped Chicken Livers	1 oz.	31	100
Chicken a la King	3 oz.	72	230
French Style Dressing	1 tbsp.	10½	60
Brown Gravy	1 tbsp.	7	21

	Quantity	Figure Control Calories	"Regular" Food Calories
Applesauce	½ cup	48	90
Fruit Cocktail	½ cup	44	90
Cherry Pie Filling	1 oz.	20	60
Chocolate Topping	1 tbsp.	8	63
Preserves (Peach, Strawberry)	1 tbsp.	9	55
"Maplette" Syrup	1 tbsp.	9	55
Liquid or Powder Sweetener	(to equal 1 tbsp. of sugar)	0	16



Complete menus, recipes, calorie chart available for professional distribution, with weight control guides you can distribute with confidence: all menus meet N.R.C. Recommended Daily Allowances. **Use this handy order form:**

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Please send____free copies of YOUR WEIGHT CONTROL PLAN for use with patients.

Dr._____

Address:_____

City:_____ Zone:____ State:_____

Highlights of The Council Meeting

(Continued from Page 22)

committee to be appointed by the Chairman of The Council).

Annual Report of Committee to Study Relationship between Doctors of Medicine and Osteopaths (referred to an ad hoc committee to be appointed by the Speaker).

Reports of The Council re Recruitment of Superior Medical Students and The Need for Financial Aid, recommending a one-time $10 assessment per member for AMAERF (The Council instructed this assessment be added to 1963 dues and returned to the two medical schools in Michigan).

- In Executive Session, The Council discussed hospital licensing bills and reiterated its previous attitude regarding proposed hospital licensing legislation.

Visit Michigan Facilities

The MSMS Special Committee on Alcoholism and Drug Addiction held a recent meeting in conjunction with a tour of the Brighton Hospital.

At an earlier meeting, the Committee visited the special alcoholic treatment facilities of the Hurley Hospital at Flint.

R. C. Bates, M.D., Lansing, is the chairman.

Section Officers Meet On Annual Session Planning

Overall planning for the 1963 MSMS Annual Session, September 25, 26, 27, were advanced at the annual fall meeting of MSMS Section Officers.

Harry A. Towsley, M.D., Ann Arbor, chairman of the 1963 Annual Session Arrangements and Program Committee, urged Section officers to offer suggestions for both speakers and topics. Doctor Towsley declared his Committee would function as a coordinating one to develop a high-quality scientific program with the aid and advice of the Sections.

C. I. Owen, M.D., MSMS President, who presided at the meeting, requested the Sections to arrange their own meetings to avoid any conflict with the 1963 MSMS State Society Dinner-Dance program of September 26. Doctor Owen also explained some of the MSMS precedents and practices for section meeting speakers, assembly officers, promotion, ticket sales and other phases of the vast Annual Session machinery.

Quoting from 1875

William Brodie, M.D., President of the Michigan State Medical Society in 1875, made this statement which is certainly so true that it deserves being quoted.

"Societies are the forum upon which observations are compared and tested, the school wherein is learned the changes and progress of diseases and the remedial agents valuable in their treatment, where intellect is matched against intellect, and where the neophyte learns to express himself and take confidence in his demonstration before his fellows."

Michigan Medical Meetings

Michigan Association of the Professions Congress, February 8-9, Jack Tar, Lansing.

Michigan Heart Day, February 8-9, Statler Hilton, Detroit.

Michigan Clinical Institute, March 13-14-15, Sheraton-Cadillac, Detroit.

Canadian-American Medical and Dental Ski Association, March 4-5-6, Iroquis Mt., Brimley.

Michigan Health Council State Conference, May 21-22-23, Pantlind Hotel, Grand Rapids.

Wayne University Medical Alumni Clinic Day, May 8, Sheraton-Cadillac, Detroit.

Upper Peninsula Medical Society meetings will be held June 28-29-30 at Sault Ste. Marie.

"State Society Nights"

Allegan County, April 9, at Allegan Health Center at 7 p.m.

North Central Counties, February 13, at Shoppenagon Inn, Grayling, 6:30 p.m.

Oakland County, April 3, at Kingsley Inn, Bloomfield Hills, 6:30 p.m.

Medical Maxims

Milk and absorbable alkalis for peptic ulcer treatment may ultimately impair kidney function.

About one-third of the population beyond middle age have small hiatus hernias that may or may not be symptomatic.

Occult loss of blood in the male usually arises in the gastrointestinal tract.

The death rate from coronary artery disease is higher than normal among ulcer patients.

Slow initial response to medical management of peptic ulcer offers a poor outlook for the patient.

—From "The Medical Maxims II" by W. S. Reveno, M.D.; Publisher, Charles C Thomas, Springfield, Illinois

what your patients need to know about Aspirin



As you know, the confidence your patients place in a certain treatment or drug often helps to reinforce the relief they get from it. That's why it's often a good idea to explain the reasons for your recommendations, even in the simplest cases.

For example, aspirin. You probably recommend it more than any other drug, as an analgesic, as an antipyretic, as an aid to sleep when restlessness is caused by minor discomforts. Certainly aspirin is the most versatile and one of the most effective drugs in the arsenal of medicine.

But aspirin is such a common and such a safe drug that most laymen vastly underrate it. To use it with the utmost confidence, they need to know more about it. So next time, take a minute or two to explain what a uniquely valuable drug aspirin really is. You know it; your patients will be reassured to know it, too.

5-grain tablets



1¼-grain tablets



For professional samples,
write The Bayer Company,
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For peptic ulcer gastric hyperacidity and gastritis...

In year-long study on peptic-ulcer patients

New Creamalin®
Antacid Tablets

*"...faster in onset of action...and for a longer period"**

"Clinical studies in 85 patients with duodenal ulcer ...confirmed the superiority of the new preparation [new Creamalin] over standard aluminum hydroxide preparations, in that prompt relief was achieved and maintained throughout the period of observation."*

Patients were followed for about one year.

New Creamalin promotes ulcer healing, permits less frequent feedings because it is so long-acting. Heartburn and epigastric distress were "...easily and adequately controlled...."* New Creamalin has the therapeutic advantage of a liquid antacid with the convenience of a palatable tablet. *It does not cause constipation.*

Each new Creamalin tablet contains 320 mg. of specially processed highly reactive dried aluminum gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles offer a vastly increased surface area.

Dosage: Gastric hyperacidity—from 2 to 4 tablets as needed. Peptic ulcer or gastritis—from 2 to 4 tablets every two to four hours. *How Supplied:* Bottles of 50, 100, 200 and 1000.

Now also available—New Creamalin Improved Formula Liquid. Pleasant mint flavor—creamy pink color. Stabilized reactive aluminum and magnesium hydroxide gel (1 teaspoon equals 1 tablet). Bottles of 8 and 16 fl. oz.

Creamalin, trademark reg. U.S. Pat. Off.

*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961.

Winthrop LABORATORIES New York 18, N. Y.

Say you saw it in the Journal of the Michigan State Medical Society

St. Clair County Society Conducts TB Skin Testing

The St. Clair County Medical Society participated in a recent pilot "Tuberculin Skin Testing Week." Twenty-three members of the Society cooperated. They or their office assistants administered 741 tests.

St. Clair County officers explain that "the idea was to give the test to all patients appearing for any reason during that week. It is hoped it will spur interest in the use of the tuberculin test among practicing physicians. The positive tuberculin reactors were urged to have chest x-rays."

The physicians were acquainted at the outset with 12 categories of patients who might be candidates for isoniazid therapy if they had positive tuberculin reactions or if their reactions were strong enough; for instance, severe or unstable diabetes mellitus, nodular silicosis, children under three years of age, patients with a pulmonary lesion and having had or undergoing a gastric resection, tuberculin converters, et cetera.

Disposable syringes, data cards, printed materials, instructions and the services of an R.N. coordinator were paid for by Christmas Seal funds.

* * *

Oakland Promotes Seat Belts

A three-pronged project to promote the use of seat belts is being pushed by the Oakland County Medical Society. The Society urges seat belts for cars driven by Oakland doctors, for taxicabs and for police cars.

* * *

Wayne Supports Fluoridation

The Wayne County Medical Society was one of the many groups to petition the Common Council of Detroit to institute fluoridation of the City water supply. The WCMS Council adopted a resolution, which in part pointed out that "It has been scientifically proven that fluoridation of the public water supplies in standards developed by the Michigan Department of Health are safe, desirable and beneficial in materially reducing the incidence of dental caries in children."



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WITH A DOSAGE AS FLEXIBLE AS ASPIRIN

The simultaneous action of aspirin and pentobarbital begins promptly and lasts four to five hours. Each tablet contains aspirin 5 grs. and pentobarbital (acid) 1/8 gr. Synirin was formulated for a two-tablet dose for adults and a one-tablet dose for children from 5 to 12 years of age. It may be repeated every four hours for the relief of pain.

Dispensed in bottles of 100 and 1000 tablets

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Kills bacteria, viruses, fungi, yeasts and protozoa on contact. Non-injurious to skin, exposed tissue or mucous membranes.

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PETERSBURG, VIRGINIA

Whatever happened
to handkerchiefs?



Remember when handkerchiefs were used for stuffy or runny noses? *That was before Naldecon.* Naldecon lets your head-cold patient breathe the way he should. Through the nose. Honest relief that lasts up to 8 hours with one sustained-action tablet. (When you need it, even *half* a tablet retains the sustained-action feature.) The counterbalance between *two* antihistamines and *two* decongestants* usually gives excellent results—seldom causes overstimulation or sedation. Keep handkerchiefs for showing. Prescribe Naldecon.

*Each tablet contains phenylephrine HCl 10 mg., phenylpropanolamine HCl 40 mg., phenyltoloxamine citrate 15 mg., chlorpheniramine maleate 5 mg.—half in the outer layer, half in the sustained-action core. Each teaspoonful (5 cc.) of Naldecon Syrup contains the equivalent of one-half tablet.

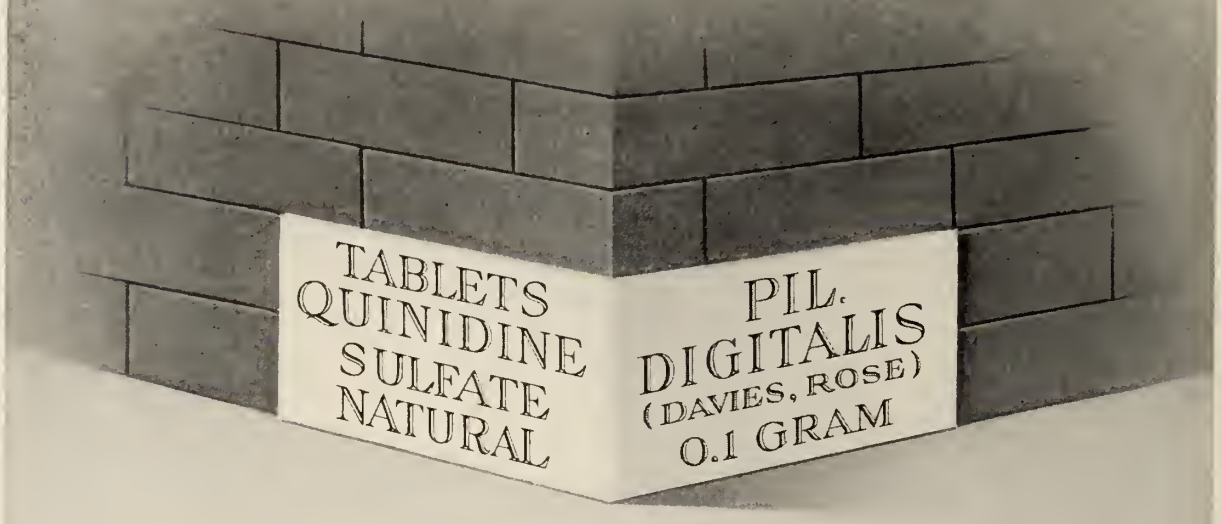
NALDECON®

long-acting nasal decongestant/ antihistamine

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A CORNERSTONE OF CARDIAC THERAPY



The Dictionary defines a cornerstone as something of fundamental importance, just as Pil. Digitalis, (Davies, Rose) and Tablets Quinidine Sulfate Natural (Davies, Rose) are of fundamental importance in treating your cardiac patients. These preparations represent 60 years of experience and dependability in the manufacture of pharmaceuticals.

Pil. Digitalis (Davies, Rose), 0.1 Gram (approx. 1½ grains) which comprise the entire properties of the leaf, provide a dependable and effective means of digitalizing the cardiac patient, and of maintaining the necessary saturation.

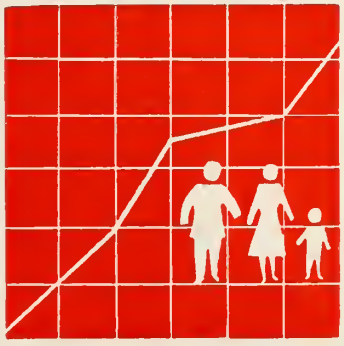
Tablets Quinidine Sulfate Natural, 0.2 Gram (approx. 3 grains) are alkaloidally assayed and standardized, insuring uniformity and therapeutic dependability. Each tablet is scored for the convenient administration of half dosages.

Davies, Rose & Company, Limited - Boston 18, Mass.

DQ-2

The Rainbow of Health Choices

By C. T. Hardwick, Ph.D.
Michigan State Medical Society Consulting Economist



Economic systems are deeply rooted in the personal and group values of the particular people living at a time and place in history. Obviously, values change over a long period of time. For example, in the 18th Century and early part of the 19th Century, the liberals proposed the cause of individuals against the encroachment of the state. Then in the latter part of the 19th Century thinkers and writers such as Thomas Hill Green stated the liberal position in new terms in which the state should positively assist and protect individuals from others as well as themselves.

Thus, in the 20th Century, the liberals propose the state as the center of their universe and the rights, privileges and freedom of the individual becomes secondary consideration. Therefore, it seems reasonable to expect that thinking men of each generation stop to consider their beliefs, goals and principles instead of jumping to conclusions about specific proposals as a common course of action. In these days of critical decisions, it seems imperative for us to return to fundamentals instead of snatching at expedient suggestions.

Thus, let us examine the theoretical choices facing Americans in the relationship between the *private* and *public* sectors of our economy. The core questions center around the issues of: ownership, operation and control. In addition to the two extreme choices of a purely private economy and a completely socialized economy, there are several theoretical combinations. There are at least six combinations available, namely:

1. Private ownership
 Private operation and
 Private control
2. Private ownership
 Private operation and
 Semi-private or quasi-public control
3. Private ownership
 Private operation and
 Public control
4. Private ownership
 Public operation and
 Public control
5. Public ownership
 Private operation and
 Public control
6. Public ownership
 Public operation and
 Public control

In the contemporary American scene, the mixed economy affords some general illustrations of the foregoing combination in the field of health. Thus, about three out of four physicians own their practice, operate it themselves and are under the private control of self-regulation or professional, ethical review. Also there are some voluntary

(Continued on Page 36)

from Oroya fever in Peru



o lobar pneumonia in Michigan

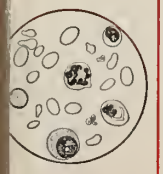
ere is a world of experience behind BRAND OF OXYTETRACYCLINE **Terramycin®**



Whether treating Oroya fever or a host of other infections, physicians throughout the world continue to rely on TERRAMYCIN for its outstanding safety, effectiveness and excellent tolerability. Not a single case of phototoxic reaction, blood dyscrasia or neurologic disturbance directly attributable to TERRAMYCIN has been reported in more than 3,000 clinical papers in the last 12 years. *In your practice, the next infection you see will very likely be "Terra-responsive."*



Oroya fever (Carrión's disease), prevalent only in certain valleys of the Andes, is characterized by a rapidly evolving, febrile pernicious anemia. The infecting organism is *Bartonella bacilliformis,* a gram-negative, flagellated organism, transmitted by night bites of the phlebotomus, or sand fly. The organism is unmistakably identifiable in blood films—no other human pathogen even slightly resembles it. The mortality rate of untreated Oroya fever can be as high as 40 per cent (in all probability, this was the disease which decimated Pizarro's army in the 16th century). Treatment with Terramycin produces dramatic reduction of fever and a stabilized blood count in 48 hours or less.

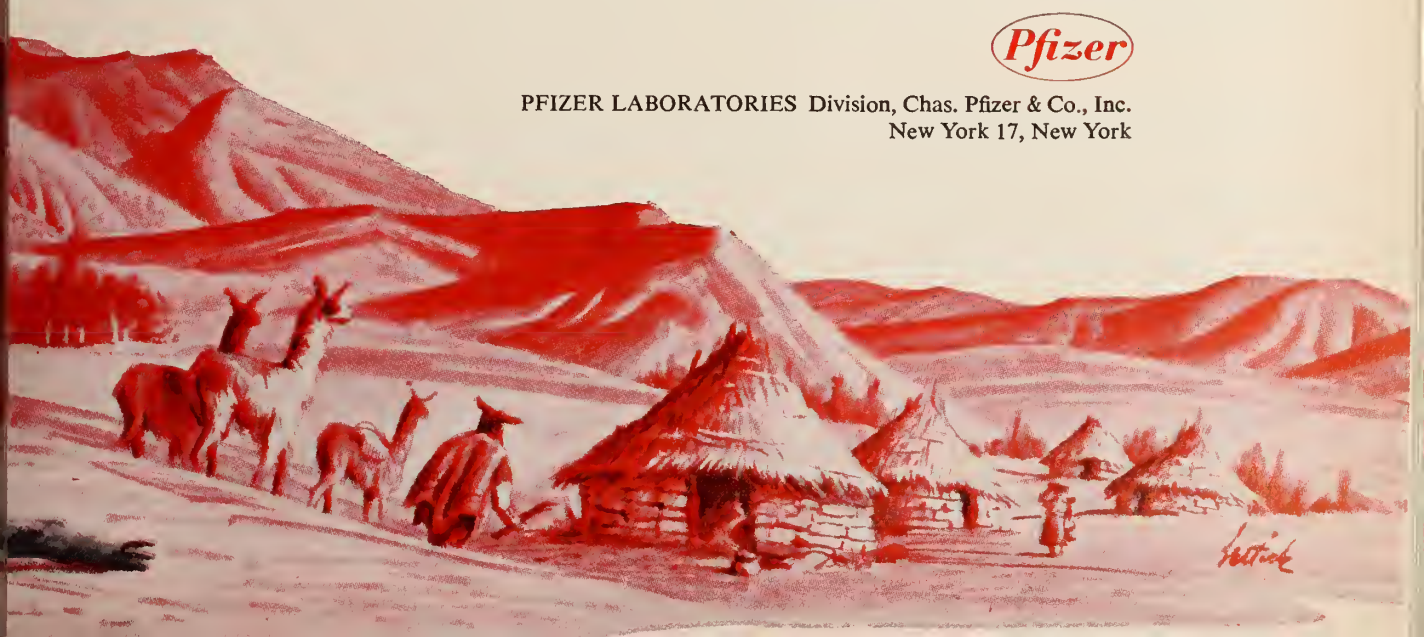


IN BRIEF The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. For complete information on Terramycin dosage, administration, and precautions, consult package insert before using. *More detailed professional information available on request.*

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Rainbow of Health Choices

(Continued from Page 33)

and privately owned clinics and hospitals, privately staffed and controlled.

In the field of hospitals however, quasi-public and public control has been becoming more common in recent years. Furthermore, for specialized care of veterans mental cases and educational needs public ownership has been accepted as the practical solution so public operation and control comes along with the investment.

In a mixed economy, the question arises as to what hybrid is to be preferred. Or, in a bias toward private enterprise, we might ask, how can private freedom to practice medicine be retained under government ownership and control. As a precautionary warning, it seems safer to retain ownership in the private hands also; however, since this is not always practicable, we should not give up entirely but rather concentrate on ways and means of preserving some private aspects of the mixed economy.

In an over-simplified approach, we are forced to seek ways of retaining private operation and some private influence of control in public-owned enterprise. This is not easy to work out because ownership rights have always implied some authority of control over operations. This, then, leads us in the direction of accepting some hospital and health programs as fully public; i.e., owned, operated and controlled. However, the dual system then demands that some other hospitals should be *privately* owned, operated and controlled. In between, some combinations of public and private may be worked out in a limited way.

In order to decide on practical combinations, it seems desirable to develop guiding principles on which to base our choice. While developing these guidelines, it might be wise to keep in sight the direction we are heading. That is, should we continue a trend toward the enlargement of the public sector or shall we protect the private segment or even reverse the trend by its enlargement.

New U. S. Public Welfare Amendments Explained

The 1962 Congress approved some Public Welfare amendments that are of interest to doctors of medicine. These amendments extend and reorient Federal-State public assistance and child welfare services programs.

The Secretary of Health, Education and Welfare presents the following explanations:

OBJECTIVES OF THE REVISED PUBLIC WELFARE PROGRAM

The Amendments emphasize the provision of services to help families become self-supporting. The States will be enabled to provide incentives that will result in a reduction in the need for continued public assistance. This approach recognizes the importance of rehabilitation in helping welfare recipients to be able as a minimum to care for themselves, and in many cases to become self-supporting. The Amendments also have the objective of maintaining and strengthening family life for children. In addition, emphasis is placed on training to increase the supply of adequately equipped public welfare personnel in order ultimately to reduce the need for and the cost of the public assistance programs.

Rehabilitation Services

Since 1956 the law has been explicit that Federal matching funds on a dollar-for-dollar basis are available to the States to provide social services to applicants and recipients of assistance. The new law increases from 50 to 75 per cent the Federal share of the costs of certain rehabilitative services to be specified by the Secretary of Health, Education, and Welfare.

Such services will have as their aim the reduction or prevention of dependency by helping welfare recipients attain self-care. Examples of these services include counseling and arranging for vocational training or medical care in appropriate cases. The 75 per cent matching also applies to funds for training personnel who are employed, or who are preparing to work, in State or local welfare agencies.

A State must provide a minimum level of rehabilitation services as prescribed by the Secretary in an assistance program (with the exception of medical assistance for the aged) in order to qualify for Federal matching funds at the increased (75 per cent) rate. The 50 per cent matching will continue to apply to social services not designated by the Secretary as well as to all other administrative costs.

Increase in Payments to the Aged, the Blind, and the Disabled

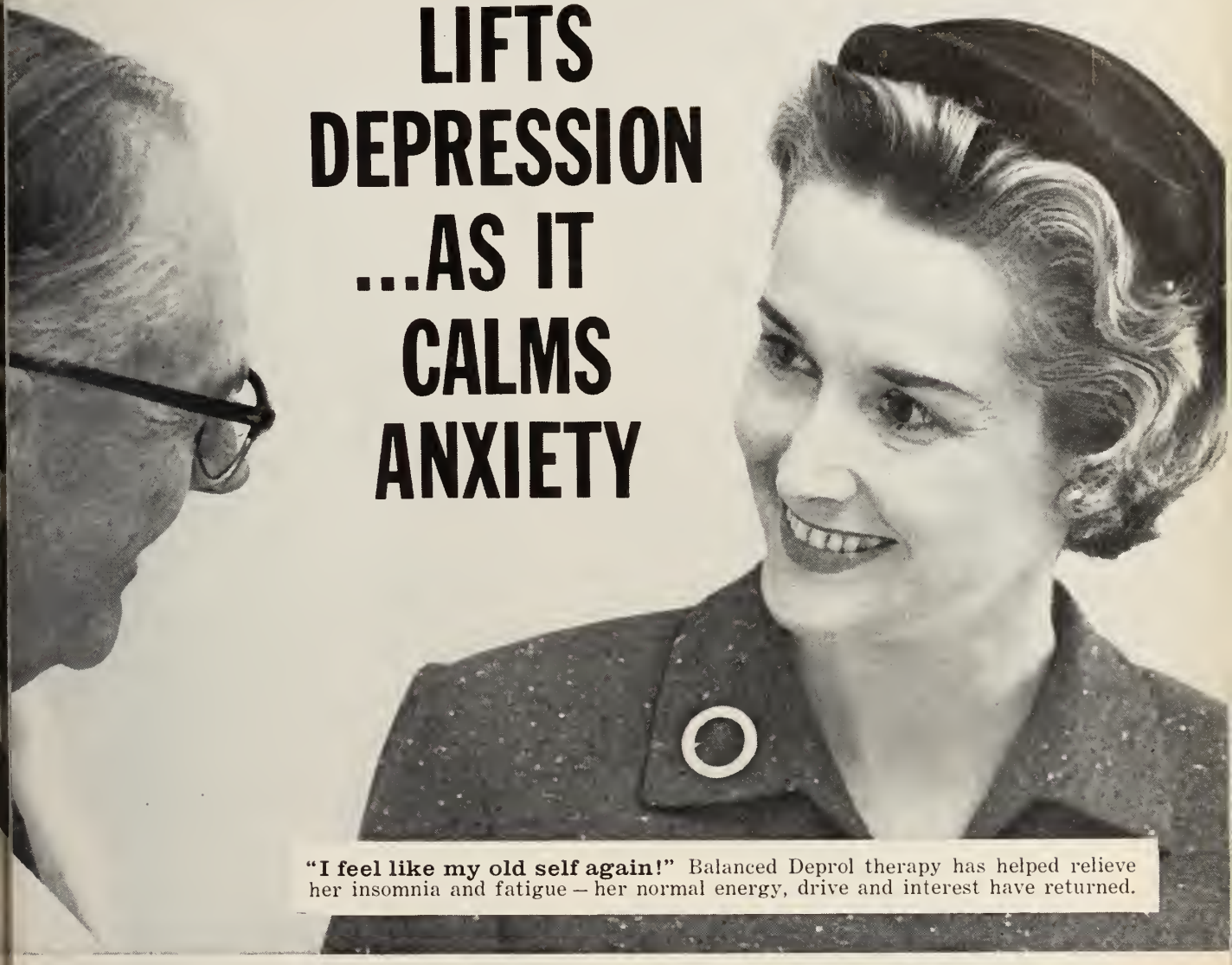
The formula for Federal participation in assistance payments to the aged, blind, and disabled has been increased by about $4 per recipient. Under the revised formula, effective October 1, 1962, the Federal government will provide $29 of the first $35 of the average monthly payment per recipient, and the ceiling for Federal matching is increased from $66 to $70. A temporary $1 increase in these payments that was enacted in 1961 and expired on July 1, 1962, will also be continued.

Aid to Dependent Children Program

The States have been given additional ways to prevent mismanagement of aid to dependent children payments. Beginning October 1, 1962, States may make

(Continued on Page 38)

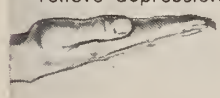
LIFTS DEPRESSION ...AS IT CALMS ANXIETY



"I feel like my old self again!" Balanced Deprol therapy has helped relieve her insomnia and fatigue – her normal energy, drive and interest have returned.

Brightens mood...relaxes tension

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Dosage: Usual starting dose is 1 toblet q.i.d. When necessary, this may be increased graduolly up to 3 tablets q.i.d. With establishment of relief, the dase moy be reduced gradually to maintenonce levels.

Composition: 1 mg. 2-diethylaminaethyl benzilate hydrachlaride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scared toblets.

Write for literature and samples.

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Taxes

The Tax Foundation reveals that the average American will work 2 hours 19 minutes of his 8-hour day this year just to pay his federal, state and local taxes. He will work only 33 minutes of his 8 hours for clothing and accessories and only 21 minutes for medical and dental care; 1 hour and 23 minutes work is required to pay for food and tobacco; and 1 hour and 24 minutes is necessary to cover the cost of housing and household operations.

New U. S. Public Welfare Amendments Explained

(Continued from Page 36)

payments to third parties interested in the welfare of the child where it is determined that the parent is so incapable of managing funds that the child's welfare is affected. This provision is limited to a five-year period and to no more than five per cent of the recipients in a State, with the requirement for a study and report of its effect and its administration. States may also give services, guidance, and advice in cases where funds are not used by a relative for the benefit of a child, and appropriate courts may impose criminal or civil penalties in such cases of misuse of funds.

The temporary provision for broadening the coverage of the aid to dependent children program to include the children of unemployed parents has been extended for a five-year period. This provision, which was enacted in 1961, expired on June 30, 1962. Aid will be denied to a parent who refuses to accept retraining without good cause.

Federal funds will be available for payments to both parents of children where the father is disabled or unemployed. Under previous law, only one adult could be counted.

Federal matching funds have been made available in cases where payments are made under community work and training programs which are part of the aid to dependent children program and meet certain standards. This provision will become effective retroactively as of July 1, 1961, and will expire on September 30, 1967. Under previous law, payments made by a welfare agency for work were financed wholly by State and local funds.

The new legislation makes permanent the provision which was enacted in 1961 and expired on June 30, 1962, that provides for payments to children removed by court order into foster home care. The law also provides for Federal participation in certain payments for foster care in child-care institutions for a two-year period beginning October 1, 1962.

Child Welfare Services

Federal funds for child welfare services are increased from $25 million a year to $30 million in 1963 and gradually increase to $50 million in 1969 and thereafter, with a specific earmarking of not more than $5 million in 1963 and not more than $10 million in subsequent years for day care services for children.

Blue Cross Changes Corporate Structure

The board of trustees of Michigan Blue Cross has revamped the corporate structure, creating new unpaid board posts of chairman of the board and two vice-chairmen. These replace the previous unpaid board posts of president and vice-president. In addition, the chief administrative post—previously that of executive vice-president and general manager—is now titled president.

Elected chairman of the board was John W. Paynter, vice-president and treasurer of the J. L. Hudson Company. Chosen as vice-chairmen were George E. Cartmill, director of Harper Hospital, and Ralph E. Phelps, assistant secretary of the S. S. Kresge Company. Wm. S. McNary, formerly executive vice-president and general manager is now the president.

Health Insurance Benefits Top 1961

Health insurance benefit payments by insurance companies ran 12 per cent ahead of last year for the first nine months of 1962. Insurance companies distributed an estimated $2,917,000,000 in benefits to persons covered by health insurance policies, an increase of 12.4 per cent over the $2,595,000,000 paid out in the same period of 1961.

The greatest amount of benefits was paid out to help cover the costs of hospital care. The Institute said the $1,163,000,000 paid under hospital expense policies in the first nine months of 1962 was an increase of 13.1 per cent over the $1,028,000,000 paid out in the same period of 1961.

Workers Take Home Less As Social Security Climbs

Medicare boosters may receive a setback when millions of employes receive their first paychecks in calendar 1963. Social Security tax deductions will jump to 3⅝ per cent of gross earnings on income up to $4,800 per annum. The 1962 rate was 3⅛ per cent. Thus

(Continued on Page 40)

asthma attack averted
. . . in minutes

patient protected
. . . for hours





Nephenalin®

(the dual-action anti-asthmatic tablet)

. . . works with nebulizer speed—provides four-hour protection

One NEPHENALIN tablet provides: *air in a hurry*—through sublingual isoproterenol HCl, 10 mg. *air for hours*—through theophylline, 2 gr.; ephedrine, ⅜ gr.; phenobarbital, ⅛ gr.

Dosage: Hold one NEPHENALIN tablet under the tongue for five minutes to abort the asthmatic attack promptly. Then swallow the tablet core for four full hours' protection against further attack. Only one tablet should be taken every four hours. No more than five tablets in 24 hours.

Supplied: Bottles of 50 tablets. For children: NEPHENALIN Pediatric, bottles of 50 tablets.

Caution: Do not administer NEPHENALIN with epinephrine. The two medications may be alternated at 4-hour intervals. NEPHENALIN should be administered with caution to patients with hyperthyroidism, acute coronary disease, cardiac asthma, limited cardiac reserve, acute myocardial damage, and to those hypersensitive to sympathomimetic amines. Phenobarbital may be habit forming. THOS. LEEMING & CO., INC., New York 17, N.Y.

Lots of Choice

The residents of every state in the Union have at least 100 insuring organizations to obtain prepaid health protection from—while in Michigan there are 248 licensed insurance companies in addition to Michigan Blue Cross-Blue Shield. There are also 13 "independent" Michigan health plans, largely community or union sponsored.

There are more than 1,800 insuring organizations actively in the health protection field in the United States now, according to the Health Insurance Institute, New York City. The people in Texas have the greatest choice with a total of 418 organizations, while those in Alaska have the smallest choice with only 107 organizations.

Workers Take Home Less

(Continued from Page 38)

workers on payrolls will take an automatic pay cut of one-half of one per cent for at least several months. Employers' contributions also increase and the self-employed tax goes up from 4.7 per cent to 5.4 per cent of the first $4,800.

Says the reliable Whaley-Eaton news service: "This new tax boost will serve as a reminder that adding medical care benefits to old-age payments will require still another increase."

Michigan Now 8th In Major Medical

There are 1,228,000 persons in Michigan covered by major medical insurance, according to the Health Insurance Institute, New York City.

In the nation, more than 36 million people—or one of every five in the civilian population—now have major medical protection.

Major medical benefits in 1961 totaled $431 million, with 1962 figures running ahead by about 22 per cent.

Michigan ranks eighth in the nation. The leaders are in order: New York, California, Illinois, Pennsylvania, Ohio, Texas, New Jersey and then Michigan.

Massachusetts "Pool" Helps Cover Aged

Forty-three Massachusetts insurance companies have joined to pool underwriting risk for major medical insurance for persons age 65 and over. Massachusetts legislature earlier had passed a law to permit this "pooling" of underwriting risk by individual firms.

Massachusetts Gov. Volpe says: "Massachusetts is indeed proud to be a pioneer in utilizing private enterprise institutions which are dedicated to helping the senior citizens of this state and their children."

Hospital-Nursing Home Relationships Discussed

The possibilities of closer affiliation between hospitals and nursing homes were considered by a speaker at the annual Michigan Nursing Homes Conference this fall at Michigan State University.

The speaker was Howard I. Wells, Jr., executive director of the Joint Council to Improve the Health Care of the Aged. In part, he said:

"Cooperative relationships between general hospitals and better nursing and custodial homes have existed for years—relationships which have strengthened each, and identified more clearly their unique contributions to the community. The degree of affiliation extending from referrals, based on mutual admiration and respect to in-training exchanges, based on the special educational resources of each . . . and even research, based on the controlled climate and patient population of the nursing home.

"As a link presupposes a chain . . . so a bridge presupposes a desirable and necessary connection between two points.

"The administrative mechanism which can provide a partial spanning is an affiliation agreement.

"The first . . . and to date only guide developed by the Illinois Hospital Association in 1961 to assist in the establishment of closer relationships between hospitals and nursing homes sets forth these overall objectives: To stimulate at the local community level:

'1. Better continuity of care for patients with chronic and disabling conditions;

'2. More effective utilization of available institutional facilities; and,

'3. A pooling of resources to provide specialized services and personnel so that they can be available to nursing home as well as hospital patients at the lowest possible overall cost to the community.'

"Elements of an affiliation agreement included in the guide are: transfer of patients between affiliating institutions; continuity of medical, nursing and dietary care; administrative and professional services; supplies; disaster planning; and, mechanisms for coordination and evaluation.

"Set patterns are not proposed . . . it being obvious that differences in local conditions and needs will dictate substantial variations in approach.

"The full potential of such cooperative relationships would seem to be limited only by the imagination of those involved."

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Severe Bilateral Monilial Pneumonia In an Adult Treated Successfully With Amphotericin B

A. F. Boon, M.D.
Ludington, Michigan



THE FOLLOWING report deals with an established case of monilial pneumonia, bilateral and severe, which showed dramatic response to the antifungal antibiotic, Amphotericin B, after remaining refractory to other treatment. There exists, presently, a relative paucity of recorded cases of both disseminated candidiasis and pulmonary candidiasis in the literature. In recent years, however, investigators have published an increasing number of reports dealing with the pathogenic potentialities of *Candida albicans* in the establishment of monilial fungemia, monilial endocarditis, and other monilial diseases, including pneumonitis.[1-6] This report may prove of moderate interest from a diagnostic point of view, but is presented chiefly because of the apparently decisive clinical effect which the antifungal agent exerted upon extensive monilial disease, pulmonary in location and instance.

Report of Case

Pre-admission.—A 60-year-old white woman was seen in the outpatient department with complaints of fever, chills, and severe cough for the preceding 24 hours. Examination showed oral temperature of 100° with clear lungs; impression of acute bronchitis was recorded; patient received intramuscular penicillin, oral sulfonamide, and cough syrup.

First Admission.—When seen three days later, the patient's condition had worsened considerably; she complained of right posterior chest pain of increasing severity, aggravated by frequent episodes of non-productive coughing. Temperature was 102°, with dullness to percussion over the right lower lung, posteriorly, where coarse and fine râles, accompanied by a pleural rub, were noted. Remainder of examination was essentially normal, and past history was non-contributory. Urinalysis showed 10.15 pus cells/hpf; hemoglobin was 12 gms., with WBC of 8,700 and 75 per cent polys. Chest x-ray examination revealed a right central consolidation extending into the lower lung field, supportive of a radiologic diagnosis of pneumonia. (At a later date, an upper gastro-intestinal series would prove negative.) Patient received Bicillin® CR daily for six days, and Mysteclin® q.i.d. for eight days, when Albamycin® was substituted for the latter drug. Oral evening temperatures of 101° or more were recorded for the first eight days of hospitalization, and averaged 99° for the remainder of the patient stay. By the eleventh hospital day, the patient appeared improved, with lungs becoming clear to percussion and auscultation at that time. Hemoglobin was 12.6 gms. with a WBC of 12,000. Chest x-ray examination, however, indicated further increase

in central and posterior infiltrations on the right, with no evidence of clearing; the possibility of an adjacent right hilar neoplasm was advanced by the radiologist. On the thirteenth day, the patient was transferred to another hospital for diagnostic evaluation. There, skin tests for blastomycosis, histoplasmosis, and coccidiodomycosis were negative. Bronchoscopy was performed and revealed no evidence of tumor; biopsies demonstrated chronically inflamed bronchial mucosal tissue; Papanicolaou smears were negative for malignant cells. All cultures of bronchial washings, however, grew *Candida albicans*. Patient was discharged and treated at home with oral Mycostatin® tablets q.i.d. Her cough worsening, and fever and chest pains persisting, readmission was advised.



Fig. 1. *(left)* Radiograph prepared on fourteenth day of patient's second hospital admission, shortly after amphotericin B treatments were commenced. The left lung field is rendered opaque by consolidation, and the right lung field is riddled with honeycombed increased densities.

Fig. 2. *(right)* Radiograph prepared on twenty-ninth day of patient's second hospital admission, two days prior to discharge. Significant, definite clearing is evident in both lung fields; atelectasis and consolidation in the left upper lobe is not yet completely cleared.

Second Admission.—Temperature 99.6°; lungs were resonant, with tactile fremitus, spoken cacaphony, and whispered pectoriloquy over the right posterior lung, and râles over both posterior lung fields. Urine showed 1-3 pus cells/hpf; hemoglobin, 12, with RBC of 3.95 and an 11,000 WBC with 71 per cent polys; NPN was 52.5 mgs. per cent. Chest plate demonstrated increase in previously noted pulmonary infiltrations on the right, atelectasis of right base, and new infiltrative process located in the left upper lung.

The patient received Mycostatin tablets q.i.d., Mycostatin aerosol q.i.d., appropriate supportive therapy, and intravenous fluids in order to depress her NPN sufficiently to allow for treatment with amphotericin B (Fungizone®). By the fifth hospital day, NPN was 48 mgs. per cent; by the eighth day, 41 mgs. per cent. On that day, she received 1,000 cc. of 5 per cent dextrose in water containing 5 mgs. of Fungizone; this dose was increased by 5 mg. increments during the ninth to twelfth days. During the six-hour course of these infusions, the patient developed chills, fever, nausea, and occasional vomiting. Because of these reactions, Fungizone infusion was withheld on the thirteenth day; at that time, NPN had become elevated to 55.5 mgs. per cent, and there was a concomitant fall in hemoglobin to 8.5 gms. Two pints of whole blood were accordingly given, with subsequent hemoglobin reading of 11 gms. and WBC of 7,150. NPN was 36.5 on the fourteenth day, when Fungizone administration was resumed, at a dosage of 25 mgs. in 500 cc. of 5 per cent dextrose in water. Transient mild chills and nausea recurred during the infusion, but responded satisfactorily to administration of quinine and Phenergan.®

From this point, Fungizone doses were gradually increased until the twenty-sixth hospital day when a therapeutic dose of 45 mgs. in 500 cc. 5 per cent dextrose in water was administered. Despite maintenance of this dosage level, there was a clinical lessening of infusion-induced symptoms previously noted.

At one point in the course of treatment, the patient developed a thrombophlebitis at an injection site which had been repeatedly used; the Fungizone concentration was decreased temporarily, with no recurrence of the phlebitic episode. During the third hospital week, there was increasing evidence of subjective and clinical improvement, but it was not until the twenty-fourth day that there was radiologic evidence of definite improvement in the previously noted infiltrative and consolidative pulmonary lesions (see accompanying roentgenograms).

By the fourth hospital week, the patient's appetite and strength had shown great improvement, she experienced no sense of fever, and her reactions to infusions were slight. During this period, NPN reports remained in the 30-35 mgs. per cent range, and hemoglobin in the range of 10-11 gms.

By the thirtieth day, lungs were clinically clear, and x-ray review showed a dramatic improvement, with significant, progress clearing of both fields. The patient had received 854 mgs. of Fungizone intravenously by the forty-first hospital day, and was then discharged to her home to continue Fungizone treatments twice a week on an outpatient basis.

This regimen was followed for the ensuing five weeks with

subsequent radiologic evidence of complete eradication of previous pulmonary infiltrations and consolidations. The patient continues regular visits with no symptoms suggestive of recurrence of disease.

Comment

No clinical conclusions may be extracted from a solitary case history. This patient had a proven, severe monilial pneumonia which involved both lung fields (Fig. 1). It remained refractory to treatment with both antibacterial antibiotics and another antifungal agent. Following several weeks of intravenous amphotericin B (Fungizone) infusions, the pneumonic process was arrested, and, apparently, completely reversed by further intravenous treatments (Fig. 2). Amphotericin B has been regarded by a number of investigators[7-9] as the most reliable antifungal agent currently available for the treatment of disseminated mycotic diseases. Continued clinical evaluation and follow-up studies of reported cases will be required to establish this view.

This particular case demonstrates an apparently remarkable therapeutic response on the part of the patient, and also tends to indicate that the side reactions of fever, chills, and other infusion reactions associated with Fungizone administration, may be ameliorated by staging of dose increments, by a slow infusion rate of six hours or more, and by applying simple adjunctive treatment with antipyretics and antihistamines. In the case described, azotemia occurred during the establishment of the amphotericin B regimen. Whatever the association may be—and most clinical reports describe a temporary azotemic phase during institution of adequate dosage levels, particularly in the earlier stages of the process—it caused only a very brief interruption of the therapeutic program. Moreover, elevations of NPN did not occur subsequently when maximum dosage levels had been applied to the patient for prolonged periods. Especially in view of the increasing frequency of recognized mycotic infections associated with antecedent or concurrent antibiotic and/or adrenal steroid treatment,[1,10] it is to be hoped that critical appraisal of this seemingly effective agent will continue, and that its usefulness may approach its potentiality. The clinical implications inherent in such a substantiation would be of the first order.

Summary

A 60-year-old white woman suffering from authenticated, severe, bilateral monilial pneumonia was treated successfully by infusions of amphotericin B (Fungizone).* Patient toleration was satisfactory, and clinical results were dramatic.

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*Amphotericin B was supplied under the trade-name "Fungizone" by Dr. John T. Groel of the Squibb Institute for Medical Research, New Brunswick, New Jersey.

Closing Wounds Without Stitches

A new microporous tape material, used in place of thread sutures to close wounds, will not only make scars from incisions and lacerations look better, but "definitely" reduce the incidence of postoperative infection, according to evidence presented to surgeons at a seminar at Atlantic City. Ten surgical investigators reported that trial use of the tape strips on more than 6,000 patients showed "definite advantages" to the sutureless skin closure.

The Use of Silicones as an Approach to the Management of Infantile Colic

James A. Dugger, M.D.
Sergio R. Inchaustegui, M.D.
Kalamazoo, Michigan

THE DIAGNOSIS of infantile colic is applied to a symptom complex occurring principally under the age of three months. It is characterized by frequent and prolonged crying episodes which seem to be due to paroxysms of pain, presumably of abdominal origin.[1] Many possible etiologies have been proposed. The very number of possibilities reveals that little is understood about the actual cause of this symptom complex and also suggests that there is quite likely more than one cause. Examples of possible sources are hunger, aerophagia, excessive eating, high carbohydrate intake, intestinal allergy, intestinal infantility, sympathotonia and anal stenosis. At least one common denominator has been suggested, whatever the original cause might have been; that the attack frequently disappears with the passage of flatus or feces.[1] Management of this symptom complex has been attempted, with varying degrees of success with sedatives, antispasmodics, formula manipulations, reduction of carbohydrate content and hypoallergenic formulae.

Inasmuch as intestinal gas in one or more of its various forms is thought to have some pertinence to the fundamental cause of the presumed abdominal pain, it would seem logical to attempt to modify the state of gas bubbles in the intestinal content to attempt to bring about relief of the symptom complex of infantile colic. The characteristics of the silicones suggest that this "antifoam" type of agent could have a significant effect on changing the gas-liquid relationship with the intestinal contents. Silicones in general are polymeric materials with a basic long chain consisting of silicon and oxygen atoms. They are physiologically inert and since they tend to decrease the surface tension of the fluid in which they have been diluted, they have been used to prevent adhesion of particulate matter and to reduce or prevent foaming and lathering of various liquid and liquid-solid phase materials.[2] These chemical characteristics have been successfully applied to defoam liquids in industries,[3] to reduce the problem of flatulance in cows and to control intestinal gas contents in human beings before gastroscopies,[4] to diminish gas patterns in radiographs of the abdomen and in the correction of adult aerophagia[4].

In order to study the application of those principles to infantile colic, a study was instituted with two factors in mind. One was to study the effect of silicones on otherwise normal children as regards its change of intestinal and behavior patterns, and in another group of children who had been diagnosed to have infantile colic, to treat the symptoms with silicone to see if there was any beneficial effect.

Material and Methods

For this study Methylpolysiloxone 40 mgs. per 0.6 cc dispensed in 5 cc bottles with calibrated dropper at 0.3 and 0.6 cc were distributed to the mothers of 20 newborns. Detailed questionnaires were given to the mothers of these babies. This questionnaire ran over a period of 15 days. Detailed questions were asked of the mother on each day regarding a battery of observations relating to the child's behavior, crying periods, stool pattern and stool consistency. The double blind method was used so that neither the mother nor the investigator knew whether the child was receiving the silicone or placebo. In addition, 14 other children were given the known active ingredient (silicone drops). In these instances, the parents were aware that the trial material was being used as an attempt at symptomatic control of the child's "colic". The dosage in all instances was 0.6 cc given after or with the last ounce of formula at each feeding. All infants in the double blind test group received the same formula except two prematures who were on a different feeding. The composition of the proprietary formula used on the majority of patients was: At a

Doctor Dugger is Chairman, Department of Pediatrics, Borgess Hospital; Associate Director, Borgess Research Department, Kalamazoo, Michigan.

Doctor Inchaustegui is Resident in Pediatrics, Borgess Hospital, Kalamazoo, Michigan.

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1:1 dilution, Protein 1.5 per cent, Fat (vegetable) 3.7 per cent, CHO 7 per cent, calcium 0.065 per cent, Phosphorus 0.05 per cent. Inasmuch as this proprietary milk contained sufficient vitamins for the child's adequate nutrition, supplemental vitamins were not included. The standard dilution used on all these children was 1:1.3 dilution resulting from a ratio of 3 ounces of the proprietary concentrated milk to 4.25 oz. of water (called No. 1). The two prematures received another proprietary preparation having a content of: 3.4 per cent Protein, 2.7 Fat (vegetable), 7.5 per cent CHO at a 1:1.4 dilution (called No. 2). The mothers were instructed to feed the children, on demand, as much as they wished to have. In the symptomatic group, no uniform formula was attempted and nine had supplemented feedings.

In order to establish a numerical scale upon which changes in either direction could be plotted, a scoring system was set up. Mothers were requested to comment on the following items; number of stools per day, consistency of stools, odor of stools, child's apparent hunger and the relative intensity and duration of the cry. The questionnaire provided the mother with descriptive terms which she could select and check each day to describe the child's performance and behavior among these categories.

The investigator reviewed the returned questionnaires and assigned numerical values according to the scales as outlined in Table III. The patients included in this study were drawn serially from a Well Baby Clinic at this institution without attempted selection. Patients were assigned alternately to Preparation A and Preparation B without knowledge as to which contained the silicone and which was the placebo. Other than the assignment of a different proprietary feeding to the prematures no difference in selection or assignment was allowed among this group. Of the original enrollees, the parents of nine of group B and 11 of group A completed the study. The makeup of the test group of patients is depicted in Table I. The 14 patients upon whom the known active material was used in an attempt to control the symptoms of infantile colic were drawn from the private practice of the senior author.

TABLE I. DESCRIPTION OF THE SUBJECTS

	Age in Days	Sex	Race	Weight Pounds	Number of Proprietary
1	5	M	W	6.7	1
2	3	F	W	3.8	2
3	4	F	N	7	1
4	3	M	W	7.8	1
5	3	F	N	5.8	1
6	4	F	W	8	1
7	6	F	N	7.8	1
8	4	M	W	6.4	1
9	3	M	W	7.6	1
10	4	M	W	4	2
11	3	F	N	6.8	1
12	5	M	N	7.8	1
13	4	F	N	5.10	1
14	3	F	W	7	1
15	4	M	N	6.8	1
16	3	F	W	7.8	1
17	4	F	W	8.10	1
18	5	M	N	6.5	1
19	3	M	W	5.6	1
20	4	M	W	6.10	1
*21	96	F	W	8	Formula, cereal, fruit, vegetable, meat.
22	42	F	W	7.10	Formula, cereal, fruit.
23	35	F	W	8.6	Formula, cereal.
24	70	F	W	9.8	Formula, cereal, vegetables.
25	60	M	W	8.5	Formula, cereal, fruit.
26	55	M	W	10.0	Formula, cereal, meats, vegetables.
27	18	M	W	7.2	Formula.
28	21	M	W	9.1	Formula.
29	22	F	W	7.9	Formula, cereal.
30	34	M	W	10.1	Formula, cereal.
31	20	F	W	6.5	Formula.
32	41	F	W	8.2	Formula, cereal, fruit.
33	21	F	W	9.2	Formula.
34	47	M	W	10.2	Formula, cereal, fruits, meat.

*Numbers 21-34 were patients with symptomatic colic given known silicone drugs in an attempt to control the symptoms. Constant milk formulae were not attempted in this group.

Results

Of the study group, all entrants showed a progressive increase in the consistency of their stools toward that of a more stiff pasty type regardless of whether the silicone or the placebo preparation was given. There was no notable change in stool odor nor in

the symptoms of hunger, either increased or decreased as regarding the silicone or placebo administration. Weight gain was not appreciably different. It was certainly not hindered from the expected standard. The pattern of cry as interpreted by the mother's reaction to the child's cry was unchanged during the first 30 days of life between the two groups. Acceptance of the material was universally good, there being no instance of complete rejection of the material. No secondary effects, vomiting, stomach irritation or discomfort could be identified with the administration of either placebo or the silicone material.

Among those 14 children who had symptomatic colic and who were given the known silicone containing material as an approach to therapeutic management, two had what seemed to be a successful result. The other 12 could not be accredited with any appreciable response to the medication. They went on to other and different management regimens, usually failing these also until the age of three months was attained when they recovered spontaneously. One child in the therapeutic trial group, who was five months old at the beginning of the study, was among those failing to respond.

TABLE II. QUESTIONNAIRE SAMPLE

Day	Number	Thick	Gassy	Foamy	Strains	Cries	Colicky	Bloody	Seedy	Color	Smell	Squirts
1 2 3 to 15												

Number:_____ Formula:_____

Name:_____ Preparation No.:_____

Age started:_____

Weight:_____

TABLE III. AVERAGE NUMERICAL VALUE FOR EACH PATIENT BY RESPONSE CATEGORIES
Based on 15-day Record

	Preparation	Consistency Stools	Frequency Stools	Odor Stools	Weight	Frequency of Cry	Total Points	Average
1	B	3	3	1	3	3	13	2.6
2	B	2	3	2	3	2	12	2.4
3	A	3	3	2	3	2	13	2.6
4	B	3	3	2	3	3	14	2.8
5	A	3	3	3	3	3	15	3.0
6	A	3	2	2	3	3	13	2.6
7	A	3	3	1	3	3	13	2.6
8	B	3	3	2	3	3	14	2.8
9	A	3	3	2	4	3	15	3.0
10	A	2	3	2	3	3	13	2.6
11	A	3	3	1	3	3	13	2.6
12	A	3	3	1	4	3	14	2.8
13	B	3	3	1	4	2	13	2.6
14	B	3	3	1	4	3	14	2.8
15	A	3	3	2	3	3	14	2.8
16	A	3	3	2	4	3	15	3.0
17	B	3	3	2	3	3	14	2.8
18	A	2	3	2	3	3	13	2.6
19	B	3	3	2	3	3	14	2.8
20	B	3	3	2	3	3	14	2.8
21	A	4	2	2	2	4	14	2.8
22	A	3	3	1	3	3	13	2.6
23	A	3	2	2	3	3	13	2.6
24	A	3	3	2	3	4	14	2.8
25	A	4	3	2	2	3	14	2.8
26	A	4	3	2	3	3	15	3.0
27	A	3	3	2	3	3	14	2.8
28	A	4	3	2	3	3	15	3.0
29	A	4	3	2	3	3	15	3.0
30	A	3	3	2	3	3	14	2.8
31	A	3	3	2	3	3	14	2.8
32	A	3	3	2	3	2	13	2.6
33	A	3	3	2	3	3	14	2.8
34	A	2	4	3	3	3	15	3.0

Preparation A was the silicone drop.
Preparation B was the placebo.

Comments

From the therapeutic trial using silicones both knowingly and by double blind procedure for the attempted management of intestinal disorders in children, it has become apparent that an agent which reduces the surface tensions so that little bubbles can become big bubbles and therefore pass with relief of pain, has no appreciable effect under the conditions of this study. The material is chemically and physiologically inert and produced no discernible changes in the children who received the material under the conditions described above. On several occasions, when the material was given to the children with foamy stools, it was commented that the stools were less foamy and more pasty during the administration of the silicone drops but without any appreciable improvement in the symptom complex of colic.

TABLE IV. SCORING VALUES IN THE RESPONSE CATEGORIES

Consistency Stools	Frequency Stools	Odor Stools	Weight Gain	Frequency of Cry
1. Watery	1. None in 24 hours	1. None	1. Less than birth weight	1. None
2. Soupy	2. From 1 to 4	2. Sui generis	2. Same as birth weight	2. Less than usual
3. Normal pasty	3. From 5 to 6	3. Strong	3. One pound over	3. As usual
4. Firm formed	4. From 7 to 8	4. Offensive	4. From one to one and a half	4. More than usual
5. Pellets	5. 9 or more	5. Foul	5. Over one and a half	5. Excessive

TABLE V. NUMERICAL COMPARISON BETWEEN PREPARATIONS. MEAN SCORES OF ALL CHILDREN ON RESPECTIVE PREPARATION.

Preparation	Consistency Stools	Frequency Stools	Odor Stools	Weight	Frequency of Cry	Total Points	Average
A	3.12	2.92	2.36	2.96	3.00	14.36	2.872
B	2.88	3.00	2.55	3.22	2.65	14.30	2.860

Summary

A double blind clinical trial was carried out on 20 unselected newborn infants in a Well Baby Clinic. Half were given placebo and half were given a silicone containing drop. The parents were asked to fill out the questionnaire regarding stool consistency, stool number, stool odor, crying pattern, gassiness and weight gain. These questionnaires were evaluated on a 1:5 value scale for each item. The values then were averaged for each patient. An evaluation of the overall results shows that the silicone did not affect the normal newborn children in any way inasmuch as they experienced the same changes in the above items as those children receiving placeboes. In another group of children with symptomatic colic, the administration of silicone drops possibly improved two out of the 14 children thus treated. It is concluded that silicone in itself a defoaming agent is not an intestinal irritant and is not an effective agent in the management of the symptom complex of colic.

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Good Medicine

We seek and support good medicine. The better it is, the better we fare. Our theme is cooperative effort, not merely on some broad policy level, but at the point where medicine meets the patient. It is not the science of medicine, but the economics of medicine that has brought the profession face to face with the threat of government dictation side by side with health insurance.—S. BRACE BLACK, Chairman of the Board, Liberty Mutual Insurance Company.

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Treatment of the Alcoholic Patient By the Family Physician

Robert A. Moore, M.D.
Ann Arbor, Michigan

ALCOHOLISM is a chronic disease manifested by repeated implicative (suspicion-arousing) or marked drinking as to cause injury to the drinker's mental or physical health, or to his social or economic functioning."[1] Though there is no better definition, its vagueness means that many patients seen regularly by any busy practitioner might well be considered as alcoholic and benefit from appropriate handling.

There continues to be considerable difference of opinion as to the etiology of alcoholism. Proponents of each idea tend to find enough evidence to support themselves but not enough to settle the issue. Since the etiology, which probably varies from case to case, is uncertain, an unfortunate corollary is that there is no single treatment approach that will assure success. Consequently, diverse techniques seem to achieve about equal results. The common denominator in success is the physician's understanding and realistic attitude, no matter what technique he has employed.

Attitude

The ability to achieve the proper therapeutic attitude requires knowledge of several people and how they interact—the patient, the spouse and dependents, and the physician (himself). The physician's attitude must be sincere—not an act readily seen through by the hypersensitive alcoholic. The usual alcoholic patient has come to anticipate criticism and rejection, or its opposite, condescension and pity. His own inner sense of badness and unlovableness causes him to test the attitudes of others with an uncanny accuracy.

The alcoholic patient gives the outward appearance of a self-indulgent, irresponsible child dedicated solely to his own pleasures. He feels he must immediately be gratified and is heedless of the pain he inflicts on others. The observer of such a person, in our concern the family physician, finds himself reacting at first with faint amusement, pity, and condescension, and then with growing anger and impatience. It is unpleasant for the physician (who after all requires a touch of omnipotence if he is to be an effective healer) to see his ministrations being ignored or resulting in no improvement. His failure leads him to blame the ungrateful patient, accusing him of lack of motivation to get well and thus, perhaps, absolving himself from further responsibility. Of much greater importance is the deep and usually unconscious resentment felt toward the perpetual child by those of us who have been able to (have had to) renounce such primitive strivings for the sake of maturity and success.

The physician may very humanly react in one of two extremes. Perhaps the most common is thinly disguised anger hidden by various rationalizations. Selzer[2] has demonstrated how such anger makes it very difficult for the physician to work effectively with the alcoholic. A second attitude often seen appears superficially to be the opposite—the physician is very kind, understanding, sympathetic and indulgent till he diminishes whatever wish for change the alcoholic had and finally gives him enough rope to hang himself (sometimes almost literally). This is a reaction-formation or the adopting of an opposite attitude to avoid realization of an unacceptable attitude (rage). This may be just as dangerous for the alcoholic since the underlying rage eventually finds its target by encouraging the alcoholic to continue his self-destructive behavior.[3]

Perhaps, if a clearer picture can be obtained of what the alcoholic is really like beneath the stereotype of the happy-go-lucky drunk, the physician will be able to be more objective about the patient's continued overindulgence. The alcoholic is rarely happy and gregarious, almost never really satiated, and finds little actual pleasure in his indulgence. Typically, he is schizoid, depressed, passive, relatively asexual, and constantly seeking gratification or satiation but never quite finding it. He achieves relatively little feeling of closeness and comfort in relationships with others and his constant feeling of isolation is a never-ending dull ache that even alcohol can never quite blot out. Episodes of clinical depression are common and suicide is a frequent danger. His pervasive anger, often only expressed in a sucking hostility, prevents him from gaining the very love and approval he demands thus perpetuating his infantile disappointment. The bottle and its warm, sedating content becomes for him his last source of comfort and protection and he battles

Doctor Moore is Assistant Professor of Psychiatry, University of Michigan Medical School, Ann Arbor, Michigan, and Clinical Director of Training and Research, Ypsilanti State Hospital, Ypsilanti, Michigan.

valiantly to protect this last hope. The physician, then, becomes the target for an intense ambivalent struggle. He offers kindness, reality, and relief from suffering, but he also represents a threat to strip away what the alcoholic feels is the only thing of importance left to him: his alcohol. Many a physician, with the most sincere and kind intent, has been baffled and hurt when the alcoholic patient turns from him and goes on a bender, often about the time it seems some success was being achieved. At this point, the balance between the positive and negative meanings of the physician has shifted to the negative. Such shifts occur frequently in the prolonged treatment of an alcoholic and the physician should not feel himself a failure when it occurs.

What, then, is this ideal healing attitude? Of course, there is no magic. The physician must be able to maintain a sincerely kind feeling of interest for the patient's well-being. He must also be honest with himself and recognize that there are times he feels angered and threatened. He should attempt to maintain a non-judgmental attitude; however, not blaming the patient does not mean to absolve him from facing the realities of his behavior and its necessary consequences. A firm, consistent approach is essential, limiting the area for manipulation, special favors, etc. At the same time one must be alert to the possibility of using firmness as a rationalization for a punitive or deprecatory attitude.

Since we recognize the alcoholic's intense need for alcohol, we are not surprised at the struggle he puts up to resist seeing that he must relinquish alcohol. Until this denial of the need to stop drinking is somehow diminished, there will be no change in drinking habits. Thus, the patient's denial of his alcoholism becomes the primary target for the physician.[4] This is not easy to accomplish (if it were, the treatment of alcoholism would be simple) and no rules of conduct are available. With as much understanding of what his patient is enduring as he can muster, with as much personal feeling of acceptance as he is capable, the physician repeatedly, kindly, realistically marshalls the facts for the patient. An effective technique is the use of the leading question that results in the alcoholic drawing the conclusions, questions that lead him to relate the harm his excessive drinking has brought to him and his family, or questions that lead him to an awareness of the positive gain from abstinence. Does one time do it? Ten times? For some, it will be a perpetual struggle. For most, the degree of denial will broadly fluctuate often to the dismay of the physician who thought this question had finally been answered for all time. Scare techniques, exaggerations and threats are to be avoided.

Time must pass, sometimes years, before this insight is really accepted. Crucial to its acceptance is the patient's trust and feeling of support from the physician.

Support of the Family

Very often, rather than the alcoholic consulting him, the physician is sought out by the family. No one can question the suffering these families have experienced and they deserve the utmost consideration. They, too, struggle with their sense of rage and hurt, alternating between open rejection and defensive excuse-making for the offending family member. If the family, especially the spouse, is given an opportunity to see that their rage is understandable and forgiveable, there is greater chance they will be able to sincerely accept the alcoholic as a sick person. Unfortunately, some have misunderstood the concept of the alcoholic being sick to mean he should not be held responsible for his acts or undeserving of criticism. As a result, oftentimes the family is so guilty over their anger that it prevents them giving the alcoholic proper impetus toward the necessary treatment.

Very often the spouse feels she should resort to threats of divorce or separation to force the alcoholic into treatment. Such bluffs are rarely successful and the dishonesty in it should not be extended to a cooperating physician since it may well make future rehabilitation more difficult. Certainly there are times when the spouse has enough reason to separate, not as a bluff. It is a common observation though, that with loss of family ties, the hope for recovery is much diminished. This final loss of love objects may leave the alcoholic firmly and unchangeably convinced the bottle is his only remaining source of gratification.

Without bluffs, but with realistic concern and insistence, the family should be assisted in pushing the alcoholic toward help. Sometimes employers and even court action are required to provide the necessary coercion. Often one hears the statement made that the alcoholic can't be helped till he wants to be helped. It is usually a long and unhappy wait before the alcoholic has such a wish and the biggest part of the battle is shortening this wait through pressures of various kinds, if nothing else the pressures of reality. We can't wait till he passively surrenders—by that time he is either 90 per cent cured or more likely on death's bed.

Support of the family also includes rather careful evaluation of the marriage. Not uncommonly one discovers a paradox—the spouse has grievously suf-

fered and sincerely wants an end put to this nonsense but, without being aware of it, acts in ways to promote continued drinking. This may be in such rational ways as providing alcohol to keep the alcoholic at home for his drinking; or, conversely, pouring his whiskey down the sink, so enraging him that he stalks out of the house, heads for the nearest bar, and is off on a bender. Usually it is more subtle. Because of early experiences, some women cannot tolerate a love relationship with a powerful man, so must insidiously undermine their husband in a way to promote irresoluteness and passivity. The alcoholic husband satisfies unconscious needs so opposite to conscious wishes they would be offended if it were bluntly proposed to them. However, the physician in a friendly counseling approach may be able to at least modify the wife's behavior in such a way to bolster the confidence of her husband struggling not to take the next drink. Investigation of such practical problems as who writes the checks, who makes small daily decisions, et cetera, may be useful. The wife willl usually say she was *pulled* into doing these things but often the physician will discover she *pushed* her way in. It goes without saying that enormous tact is required in dealing with such problems. The physician who optimistically believes all people really want to be well and happy may himself be so threatened by the great unconscious tendency many have to be sick or live in an unhappy situation as to have difficulty approaching these areas.

Medical Treatment

Thorough physicial evaluation of possible effects of malnutrition or toxicity from the alcohol itself is essential. Common findings include portal cirrhosis, peripheral neuritis, and chronic gastritis. Less commonly seen syndromes include Korsakoff's psychosis, Wernicke's disease, pellagra and cerebral cortical atrophy.

The daily barrage of new psychic wonder drugs tells us of new treatments for alcoholism along with the rest of man's ills. These drugs are in no way specific for alcoholism but act simply as tranquilizers or anti-depressants. They may be somewhat useful in the sense they accomplish these functions to some degree. The addictive potential being so great in alcoholics, drugs that produce too much placidity or euphoria should be avoided—especially barbiturates, stimulants, paraldehyde, and chloral hydrate. Meprobamate should be used with caution. The phenothiazine drugs are safest in this sense but care must be taken because of their potential hepato-toxic effects. A safe generalization would be to use all CNS acting drugs with care, try to limit them to periods of acute upset, perhaps to avert a binge or right after one, and never give the alcoholic an indefinitely refillable prescription. Most importantly, don't feel the physician's responsibility has been discharged by giving a prescription.

One of those wonder cures that has tarnished with age is Antabuse. It is only as effective as the alcoholic's wish to be helped—thus it is a drug to use in an early alcoholic who is scared, or in an old one who after a long struggle sees the need to stop drinking but fears he cannot control the impulse. Some criteria for its use are:

1. The patient is intelligent enough to comprehend the dangers of an Antabuse-alcohol reaction.
2. The patient has considerable desire to prevent impulsive drinking.
3. The patient is willing and able to return for periodic appointments (no refillable Rx advisable).
4. The patient is free of cardiac decompensation, coronary heart disease, chronic kidney or liver disease, hypertension, diabetes mellitus.
5. The patient is not psychotic nor prepsychotic. (Such forcible removal of alcohol might precipitate the psychosis into the open.)

Hospitalization

Hospitalization for severe complications requires no elaboration. Certainly, the alcoholic with delirium tremens requires instantaneous hospitalization as this can be a fatal illness. Treatment of this frightening condition is better described elsewhere.[5] "Drying out" for a few days can be done now in an increasingly large number of general hospitals without resorting to fictitious diagnosis to get by the hospital administration. Decisions to hospitalize in these above situations are rather easy to make.

More difficult is making the decision for psychiatric hospitalization. For a long time the only treatment available was to "put him away" for a while. Since the results were so disappointing there developed a resistance to psychiatric hospitalization for alcoholics. Now there seems to be a return to this method, including involuntary hospitalization.[6] Of course, more has to be done than merely putting a locked door between ethanol and the addict. It is common now to find specialized group therapy for alcoholics, Alcoholics Anonymous chapters, work rehabilitation programs, as well as general physical rejuvenation and judicious use of CNS-acting drugs available within the hospital.

The major indications for psychiatric hospitalization of the alcoholic are (a) suicidal or homicidal threat,

and (b) a complete inability to stop drinking unless hospitalized. Hospitalization in a private sanitarium may be feasible for some but most will have to depend on public hospital care if the period is prolonged. Many states provide for commitment as an alcoholic to a state institution and it may be an act of great kindness to take advantage of this when voluntary methods have failed.

Referral

While we may recognize alcoholism as a mental illness, it is not feasible for the few psychiatrists in most sections of the country to treat all alcoholics. The family physician much more often is the one who does the difficult work. He may, on occasion, wish for a psychiatric referral. Reasons might include:

1. There is a question of psychosis.
2. The alcoholism is of short duration, following severe emotional upset, in a more mature personality. This may then be a psychoneurosis amenable to psychotherapy. (Most alcoholics are not neurotic but usually suffer from a character disorder.)
3. The family physician wants advice as to handling the alcoholic or in supporting his family where there is more-than-usual complexity.

It may be possible to refer the alcoholic to a publicly supported alcoholism clinic since an increasing number are being opened about the country. Here, he can be given supportive counseling or sometimes brief psychotherapy. However, it will probably be most successful if the family physician maintains concurrent interest and responsibility by cooperating with the clinic in whatever way seems mutually useful.

Alcoholics Anonymous is seen by many as a panacea and by some as valueless. Neither is correct. Unfortunately, Alcoholics Anonymous requires at least partial recognition of the need to stop drinking and as a result the vast majority of alcoholics are very resistant to AA. For the one who is able to see the need for AA help this may be the best "treatment" available for him. It may require a considerable period of push by the doctor to get him there. Certain patients will not accept AA even though recognizing the seriousness of their drinking. Non-religious patients or those with certain moral or philosophic beliefs might be offended by such a referral. The physician should not act as an evangelist for AA. If his patient does go to AA, medical responsibility is not reduced and contacts should be maintained.

Community Responsibility

The physician's unique community status allows him an opportunity for community education on the problems associated with alcoholism. There is a growing public interest in alcoholism and the informed physician may help satisfy this by speaking before various service, church and commerce groups. Many states require teaching about alcoholism in the public schools and might make use of an interested and informed physician. Perhaps he may be of service to a struggling new community-wide group that is trying to set up a clinic or information center for alcoholics or perhaps he may be the stimulus to start such a movement. Help for such a movement may be obtained from the National Council on Alcoholism, Inc. (New York Academy of Medicine Building, 2 East 103d Street, New York 29, N. Y.) or from his state's commission on alcoholism.

It is a moot question whether a physician should identify himself with "wet" or "dry" groups if there is community debate. As a citizen he has every right to do so if he approaches it as a moral issue, but as a physician he may be giving scientific medical sanction to a moral opinion.

Conclusion

Though there is voluminous literature on various treatment approaches for the alcoholic, the essential element is too often underplayed. This element is the feeling the physician has toward the alcoholic and his family and how the physician may handle these feelings. No matter what technique employed, if the physician recognizes the alcoholic as a sick person, terribly lonely, often frightened, and despondent, yet also infantile, demanding, and insatiable who provokes much anger in those who try to help him, he may be gratified by his successes. He should not be indulgent or permissive, but firm, realistic and consistent, yet within a framework of kindly concern. His help may well have to be extended to include the alcoholic's family. A brief review is included of general medical treatment, reasons for hospitalization, sources of referral, and community responsibility.

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Anatomical Material and the Physician

Russell T. Woodburne, Ph.D.
Ann Arbor, Michigan

THE PHYSICIAN understands the vital role played by anatomical material in the initial training of medical students and in the postgraduate retraining advisable for surgeons and other specialists. He understands that there is no way for the physician or surgeon to gain a full understanding of the human body except by direct observation and study. As a consequence, a complete course in anatomy is included in the curriculum of every medical school and additional, more advanced courses under the heading of "Surgical Anatomy" are usually provided. Further, the structure of the human body is also essential knowledge for dentists and nurses and is desirable for those entering careers in physical therapy, physical education, and other health-related fields. Educational programs in all these areas are being expanded and, as a consequence, the availability of bodies for observation becomes a matter of great concern.

Since colonial times in this country, the need for dissection material and the necessity of disposing of unclaimed bodies were recognized by laws which provided that bodies unclaimed for burial by friends or relatives became available for medical teaching purposes. Such provisions, while useful, did not provide a completely adequate supply of dissection material, and the short but unsavory period of our history characterized by grave-robbing ensued. In spite of rumors that continually circulate to the contrary, there has never been a commodity market in human bodies; individuals cannot receive, while living, monies for the use of their body after death. The wide establishment of state institutions, in which individuals stayed for many years and frequently died "unclaimed" by relatives, subsequently resulted in a considerably greater supply of bodies for medical studies. However, in more recent years, the emphasis on a "decent" burial and the politically attractive provisions in social welfare, veterans, and social security laws aimed at providing funds for burial have seriously undercut the supply. Fortunately, in the meantime, medicine and surgery have found ways to utilize the corneas from the recently dead, and transplantation techniques have been developed for the use of skin, blood vessels, nerves, and bone. The more socially conscious element of society immediately recognized that these were great benefits to living man, and it has not been difficult to show such individuals that the complete utilization of the body in medical studies can be of inestimable value to society.

A survey in 1954 showed that only 10 states had statutes providing for the legal donation or willing of bodies or body parts, but by 1959 a total of 25 states had bequest laws on their statute books (R. T. Woodburne: Anatomical Materials and Anatomical Procurement. Anat. Rec., 136:1, 1960). In the past several years, several states have been added to this number. In 1958, the legislature of the state of Michigan passed two laws of great significance in this regard. One of these is the new anatomical act (Act 138 of the Public Acts of 1958) which provides more certainly and more justly for the delivery of unclaimed bodies to the medical schools of the state. The other, Act 82 of the Public Acts of the State of Michigan of 1958, authorizes gifts of the human anatomy or parts thereof, and prescribes procedures for such gifts and the rights, duties, and liabilities of the parties to the gifts (Fig. 1).

Based on this law, the medical schools of the state of Michigan have provided a gift form (Fig. 2), which indicates the approved means of making the donation of the body for medical studies. The form is executed in triplicate, and, according to the law, one copy is filed in the Probate Court of the county of residence; one copy is then delivered to the donee; and one is retained by the donor. It is also possible to incorporate such a declaration in a will; but since wills are sometimes not examined until after a body is buried, it is possible that the testator's wishes are not understood in time to take proper action. It is also ad-

Doctor Woodburne is Professor of Anatomy and Chairman of the Department of Anatomy, The University of Michigan Medical School, Ann Arbor, Michigan.

visable for the donor to talk the matter over with his next-of-kin or with whoever is likely to be charged with the arrangements necessitated by his death.

burial service is conducted at the interment with the University Hospital chaplain presiding. The Wayne State University Medical School has similar but not

AN ACT to authorize gifts of the human anatomy or parts thereof; to prescribe the procedure therefor and the rights, duties and liabilities of the parties to the gifts.

The People of the State of Michigan enact:

Sec. 1. Every person of full age and sound mind, by written instrument, may give all or any part of his anatomy to any medical or educational institution or to any person. The part of the donor's anatomy shall be used for the purpose specified in the instrument. If no purpose is specified, then the donee may use it for any medical or educational purpose.

Sec. 2. The written instrument shall be signed by the donor in the presence of 2 competent witnesses and the execution thereof shall he acknowledged before any person who is authorized to take acknowledgments within this state.

Sec. 3. The written instrument shall be deposited and retained on file in the probate court of the county wherein the donor resides. Duplicate originals of such instrument may he given to such other persons as the donor may choose.

Sec. 4. Upon the death of the donor, the donee or his agent may claim the body and may cause to he removed from the donor that portion of his anatomy given the donee: Provided, That the donee or his agent shall use reasonable care in removing the portion of the anatomy so donated to avoid undue mutilation of the body. If the entire body is given, it shall not he delivered to the donee or his agent until after the surviving spouse or next of kin has had an opportunity to provide a funeral service or other last rites for the deceased.

Sec. 5. The gift of any person of all or a portion of his anatomy made pursuant to the provisions of this act may be revoked by the donor hy demanding return to him of the written instrument of gift, and any duplicate originals thereof, from the person in possession of same, or by written instrument executed and filed in the same manner as the original gift.

Sec. 6. Any licensed medical practitioner or medical or educational institution, who removes the portion of any donor's anatomy given as provided in this act, shall not be liable for damages in any civil suit for the removal of the part so given unless the gift has been revoked in the manner prescribed by this act.

Sec. 7. Any person who delivers or permits the removal of all or any portion of the donor's anatomy or who fails to deliver or permit the removal of all or any portion of the donor's anatomy, shall not he liable in any manner unless he has actual knowledge of the gift or its revocation.

Approved hy Governor, April 11, 1958

Fig. 1. Act 82 of the Public Acts of the State of Michigan of 1958.

In general, the funeral directors of the state understand the procedures necessary for transportation of bodies to the medical schools of the state. Bodies should be received by the medical school as soon after death as is possible. On arrival, they are carefully embalmed and, as teaching schedules require, are made available to physicians and students. The bodies are treated with respect and are studied carefully. After the observations, which usually extend over several months, the remains are cremated and the ashes are buried. The University of Michigan maintains a burial plot in an Ann Arbor cemetery, and a identical arrangements. It would be entirely feasible to return the ashes to the donor's family for a local burial or memorial service, but a request for this return should be made at the time the body is received. In view of the thorough embalming conducted in the school, it is neither necessary nor desirable to have the local funeral director embalm the body unless there is undue delay in delivery of the body to the medical school or other conditions necessitate it.

Having expressed the desire to donate his body to a particular medical school, it is always possible that death may overtake the donor in another part of the

country. Usually the costs of transportation and the dangers of deterioration preclude the return of the body to the designated institution. It is wise, for this reason, for the donor to allow his body to be given for the same purposes to an institution within the state or adjacent state where the death occurred.

Occasional public discussions, as in the August, 1961, issue of *Reader's Digest*, call attention to the great need for anatomical material in the training and postgraduate study of physicians and surgeons. Such discussions frequently lead to queries being directed to the local physician, and it is to aid him in answering such questions that this discussion has been inserted in THE JOURNAL. The Department of Anatomy of the University of Michigan Medical School welcomes inquiries and will be happy to supply additional information on points which may need further clarification.

Pursuant to the provisions of Act 82 of the Public Acts of Michigan of 1958 (as printed on the reverse side of this form), I hereby give my body, to be delivered after my death as provided in the aforementioned law, to The University of Michigan Medical School to be used in the advancement of medical education and research.

To fulfill the purposes hereby intended, my body is not to be autopsied since an autopsy would render it unusable. However, if my next of kin should grant permission to perform an autopsy which is deemed to be necessary, then my body is to be buried at the expense of my estate or next of kin and notification thereof given to the donee.

If I should die outside the State of Michigan, at a distance greater than 125 miles from Ann Arbor, it is my wish

Check one

☐ that my estate or next of kin pay the costs of transporting my body to The University of Michigan Medical School, Ann Arbor, since the University is not able to pay excessive transportation costs.

☐ that my body be delivered to the nearest medical school.

☐ that this gift shall be null and void.

WITNESSES:

.....

.....

DONOR

.....

ADDRESS

STATE OF MICHIGAN }
COUNTY OF } SS

On this day of A.D. 19....., before me, a Notary Public in and for said County, personally appeared known to me to be the person named in and who executed the foregoing instrument and acknowledged that he executed the same as his free act and deed.

.....

NOTARY PUBLIC

EXECUTED IN TRIPLICATE
1 FILED IN PROBATE COURT
1 DELIVERED TO DONEE
1 RETAINED BY DONOR

Form 8163ML

County of
State of Michigan
My Commission Expires:

Fig. 2. Form used in Michigan for gift of human anatomy to an educational institution.

Concerned About Health of Middle-Aged

"We're neglecting the middle-age segment of our population in our concern for the health of the very young and the very old," contends John A. Cowan, M.D., director of the Michigan Department of Health's Division of Tuberculosis and Adult Health.

In speaking at a regional meeting of the Michigan Education Association in Ann Arbor, Doctor Cowan stressed the importance of health conservation in the 20 to 45 age group through periodic health examinations. He said that many of the chronic diseases afflicting those in later years could be prevented by early detection and treatment in younger years.

Dr. Cowan cited a recent national health survey which revealed that approximately 35 per cent of the population in the 20 to 45 age group has one or more chronic disease conditions.

The public health physician told the educators, "Each of us should have a personal physician whom we should know and who should know us sufficiently well so that if illness or disability should occur, the physician has a background of information obtained from us when we were apparently well physically, mentally, and emotionally."

Looking and Listening in Clinical Work

Theodore A. Watters, M.D.
New Orleans, Louisiana

IN SPITE of the advance of medical science and the development of various techniques and tests, there is still great need for the exercise of clinical acumen and judgment. In the ultimate analysis, medicine advances by virtue of the human component. Therefore, we make a strong plea for those in practice not to forget the primary obligation to the patient and his well-being. Our duty as doctors is to assist people to get well rather than to devote ourselves too exclusively to the more impersonal prerogatives of science. Our main preoccupation is with the reality of symptom formation. But that is not looking far enough into the past, nor yet into the future. We must be quicker to detect the first faint aura of illness, using highly refined skills of looking and listening, observing, hearing, and inferring from what was heard and observed through our trained perceptive apparatus.

Various difficulties stand in the way, however, when we attempt to understand what is perceived and heard. For one thing, problems of translation are involved, since communication is seldom a simple matter.[2] Many patients are reluctant to express themselves directly to a physician. In seeking help for what is really a medical problem, they may go all around Robin Hood's barn because of some misconception about the proper person to approach, and some doubt about what reception it would have from a doctor. One man may consult his minister about an emotional problem; or his lawyer about a marital difficulty; a personnel director about domestic trouble; a teacher about his child's troublesome behavior at home. Yet in all these cases the physician would have been the proper advisor. Other persons may talk in terms of a third person, in an attempt to test the doctor's reaction to what is really their own problem. Patients, too, will attempt to capture an interested audience for their afflictions, and dramatize elements that they feel would attract the attention of the physician and insure his solicitude. This maneuver may actually conceal the real problem for which they are seeking aid. Those who use various complaints as a passport for frequent visits to the physician, quickly develop others as fast as improvement is shown.

Another difficulty in assessing these problems, is that rarely do mental disorders manifest themselves in the clear-cut terms so well described in the medical texts. Moreover, they are usually preceded by familial conditions in early environment and experiences undergone in the period of growth and development that may predispose the person to mental illness later on in life. Disappointments, deprivations, frustrations, and abuses are later woven into patterns of tension that can be so fateful for the individual.

From the vantage point of long contact with a particular patient, and possibly his siblings, parents, and grandparents, a physician can detect squeaks and rattles in his functioning. He has at his command a knowledge of behavior appropriate to this person at a certain age in a certain culture in a particular social, economic and political mileu at a particular time. These early indications are not necessarily symptoms, but they can be tension phenomena which if ignored can become more permanently fixed, later to be identified when they emerge as what we traditionally recognize as symptoms of mental disorder. Awareness of the many implications of deceptively simple physiologic manifestations, may nip in the bud what otherwise may bloom into mental illness. Additional inquiry into the particular circumstances of the patient's life may reveal the area of difficulty to be in his psychosocial adaptation. The clinician's knowledge of early experiences and how they effectuate potentials for later difficulty, enable him to interpret present echoes of earlier problems. He can predict that without human understanding they may evolve at a later time into mental disorder.

These early indications of shoals ahead can be very subtle. Possibly, the first ripple may be an alteration in thinking patterns. Interestingly, Learoyd speculates that "the stream of consciousness is the most delicate gauge of health, and any disease or poisoning will show itself first by showing a regression in the mode

of thought. It is the only way the mind can act in adversity."[1] The physician may ascertain through questioning the patient's present state of mind, for example, with regard to a normal social life. One clinician has frequently loosened a patient's tongue by asking whether he went to the movies any more.[4] If he remarked that he no longer enjoyed them as once he had, that could be an early indication of a slipping hold on living in the present. A patient may reply to a question by asking one of his own which will be related to the subject, but tangential. A strong tendency toward literal thought is in evidence.[3] If this is suspected, one physician suggests asking the patient to explain the meaning of a well-known proverb. The symbolic meaning will certainly be missed by the prepsychotic.

Various discrepancies in different areas of functioning may also be indicative of a change in the personality's performance. A discrepancy may appear between the historical account given by the patient and the physical survey. Another may occur between the complaints and the causes therefor alleged by the patient. Discrepancies, too, may occur between the patient's story of conditions in his life at home and adverse factors apparent to the doctor during a home visit, or brought out in an interview with the patient's spouse or other members of his family. Discrepancies between over-frequent visits to the doctor's office and a lack of demonstrable reasons therefor may indicate a more covert psychological problem. Too, unsatisfactory response to appropriate treatment over a reasonable period, might lead one to suspect reasons for seeking help other than the ones given.

Changes in customary behavior can be significant, too; sometimes we see a formerly meticulous person becoming careless in habits of cleanliness and dress, or wearing clothing inappropriate for the occasion. Or a shy, quiet youth may make a sudden shift to boisterous conduct, and cultivate the companionship of social inferiors. Preoccupation with philosophical abstractions or theological problems on the the part of one who had never shown an interest in such matters can be an unhealthy sign. Too, a sudden change in political or religious views evidenced by a person who had grown up in, and accepted preferences expressed by his family can be indicative of a deeper problem. An impulsive change from one vocational pursuit to another quite different, may cause the physician to wonder what dictates this move. Suspect, too, is the person who fails to come to grips with life and remains in the shelter of his Alma Mater or other institution in an unproductive quest for degrees, or exploring different areas of knowledge, while failing to decide on a permanent choice.

Changes, too, in the biological urges bear watching. When the patient turns to eccentric diets, excluding essential foods, or increases or decreases the amount beyond what is proper and customary for him, the physician may not dismiss this too lightly. The gastrointestinal tract is a sensitive barometer of emotional disorders in many people. Cycles of weight loss or gain may parallel depressive and expansive cycles. There are also energy cycles which may or may not parallel weight cycles, found in depressive illnesses when the disturbance in mood is not too striking. One clinician[5] has emphasized the importance of the eyes in reference to depression. Often they are an active area of difficulty, but only a part of the total picture. Not uncommonly in depressions, the thermal apparatus may show capricious responses to heat—but more especially to cold. One must not neglect grief as a problem. It may be expressed quite subtly and may involve physiological components or equivalents in some persons, including children, who may grieve for a reason that to an adult may seem to be fairly trivial.

Difficulties in sleeping, intermittent sleep, early morning awakening, difficulty in falling asleep, may indicate disturbance. Excessive sleep, too, characterized by early retirement or sleeping during the day may constitute a retreat from reality, resulting from depletions in human relationships. Troubles with elimination and preoccupation with the areas involved may be prophetic of more serious difficulty. One of the keener indices of dissatisfaction is demonstrated in sexual behavior. Patients are often reluctant to discuss these intimate matters concerning the responsiveness of the other partner, as well as their own performance. Especially is this true if any pattern of perversion lurks in the background. When the physician meets with silence in the course of an interview, this may have great meaning. It can express hostility, or preoccupation with some line of thought not revealed to the physician.

Looking and listening require much expenditure of effort and energy, objectivity and suspended judgment. The doctor should be mindful that due to the intrusion of personal factors, he may inadvertently listen too selectively. This may cause him to emphasize some material that is more important to him than to the patient, and overlook other matter more central to the patient's real problem. If he could only,

through some subtle psychologic antennae, tune in on the first faint signals of impending distress, he could intervene early enough to shore up a wavering personality structure. And who, after all, is in a better position than the general physician to bend back the human twig into symmetry before the tree inclines, twisted and bent, to be uprooted by the first storm?[6] The earlier that preventive measures can be instituted, the less serious any later repairs, or, hopefully, none at all.

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429 Jona Street
Metairie, Louisiana

Arthritis of Larynx

Arthritis changes in the larynx associated with rheumatoid arthritis are more common than generally has been recognized, report Drs. Robert H. Lofgren and William W. Montgomery of the Department of Otolaryngology, Massachusetts Eye and Ear Infirmary, Boston.

In a study of 100 patients with rheumatoid arthritis, 26 were found to have definite signs and symptoms of laryngeal arthritis involving the cricoarytenoid joint.

"Cricoarytenoid arthritis associated with generalized rheumatoid arthritis is slightly more common and tends to be more severe in females," the authors said. Twenty of 68 women (29 per cent) and 6 of 32 men (19 per cent) had laryngeal involvement. "All cases classed as severe or moderately severe were in females," the surgeons added.

The most common symptoms in the study group included fullness or tightness in the throat; a sensation of a foreign body in the throat; hoarseness; difficulty in swallowing; pain on swallowing; pain when talking; shortness of breath on exertion; radiation of pain to the ears; or stridor, a harsh vibrating sound produced during respiration.

Patients with active rheumatoid arthritis elsewhere in the body usually showed a more active process in the larynx, with redness and edema over the arytenoid cartilages, the authors said. "The larynxes of patients who were in remission (inactive state of disease) most often demonstrated thickening of the mucous membrane over the arytenoid and limited motion or fixation of the cricoarytenoid joint. The activity of the disease seemed to be more important than its over-all duration."—LOFGREN, R. H., and MONTGOMERY, W. W.: Incidence of larngeal involvement in rheumatoid arthritis. *New England Journal of Medicine*, 267:193 (July 26) 1962.

The Lost Work Tr-End

Paul D. Radgens, M.D., M.P.H.
Dearborn, Michigan

VARIOUS ESTIMATES indicate that there are about 70 million people in the United States who use alcoholic beverages. Of these 70 million people, there are 4 to 5 million people who are problem drinkers and experience severe health, social, and/or economic difficulties as a result of their drinking. Unfortunately, a great majority of these problem drinkers are men in their most productive years, and a very conservative estimate would place over 2 million problem drinkers on industry payrolls alone. Prevalence rates of problem drinkers in industry vary from 0.5 to 1.1 per cent, depending on the specific survey. Problem drinking, or alcoholism if you wish, thus presents society in general, and health workers in particular with serious problems, few of which have been solved.

Definitions and Types of Alcoholism

There is no universally accepted definition of alcoholism. A good general definition is: "Alcoholism is a chronic disease manifested by repeated, implicative (suspicion arousing) drinking so as to cause injury to the drinker's health, or his social or economic functioning."[1] Alcoholism is certainly not an occupational disease, and does not concern industry until it interferes with the employe's work function. Therefore, a relatively simple definition is applicable to industrial medicine. "A problem drinker (alcoholic) is an employe whose work is materially reduced in efficiency and dependability because of excessive drinking."[2]

A useful and descriptive schema for classifying the types of alcoholism is the following proposed by Jellinek[3] in which he uses the letters of the Greek alphabet to distinguish the types:

Alpha Alcoholism.—A purely psychological continual dependence upon the effects of alcohol to relieve bodily or emotional pain. Drinking is undisciplined, but there is no loss of control or inability to abstain. There may be complications—interference with the family budget, nutritional disturbances, or occasional absenteeism from work and decreased productivity, but there are no signs of a progressive process. There may be a drinking career of 30 or 40 years without progression to physical dependency.

Beta Alcoholism.—Long-term drinking which may result in medical complications (cirrhosis, gastritis, polyneuropathy, convulsive seizures, et cetera) without either physical or psychological dependence. This is characteristic of certain minority groups, notably Italians, and has a direct bearing on custom and perhaps poor nutrition. Withdrawal symptoms do not occur. This variety is often seen and missed in the general hospital.

It should be noted that either one of the above types, especially the Alpha variety, may progress to the gamma or delta forms.

Gamma Alcoholism.—A form characterized by acquired increased tissue tolerance to alcohol, adaptive cell metabolism, withdrawal symptoms and physical dependency, and loss of control.

There is a definite progression from a psychological to a physical dependence with marked behavior changes. Gamma Alcoholism predominates in the United States and is the most damaging to health and social and financial standing. The drinking pattern is the consumption of large amounts of concentrated spirits in a short time once drinking has started, but with the ability to abstain for short periods in between bouts.

Delta Alcoholism.—Characterized by all four of the features listed above for Gamma Alcoholism, except that control is maintained within limits, but there is an inability to abstain. This type is common in France, and its pattern is consuming large daily amounts of low-content spirits in small, nonintoxicating portions over 14 to 16 hours a day every day. These alcoholics can have withdrawal symptoms without ever becoming intoxicated.

Epsilon Alcoholism.—Periodic drinking with long periods in between bouts, sometimes as long as a year or two. No withdrawal symptoms are noted.

The difference in drinking patterns is determined by social attitudes, the predominance of certain types of alcoholic beverages, by geographical location, by social gradings, and by economic factors. Within the above categories, it is important to distinguish the solitary from the socialized drinker, and the drinkers who become aggressive, hostile, and destructive when drunk from those who do not, for the symptoms at the work location are different and the prognosis for treatment is different. It should be noted that a solitary drinker can drink alone in a crowd, for he does not socialize when drinking even though people are around him, and he does not have "drinking buddies."

Solitary drinkers are more preoccupied, have more psychological involvement, more paranoid and psychotic tendencies, more disturbed social relations, are asocial, and far less concerned about getting help than the socialized drinker. They lose jobs by default, quitting, and not coming to work when drunk. They do not care. They have economic and family disruption just like the socialized drinker has, but lose community status later since they are not often seen drinking. Treatment of solitary drinkers is primarily that of resocialization. The socialized drinker loses community status earlier; people see him drunk and he takes his "drunken buddies" home with him. He is more likely to be inebriated at work. Treatment is aimed at removing him from his deviate group associations.

The drinker who becomes belligerent when drunk has a more serious prognosis than the nonbelligerent drinker. The former is jailed more frequently, has a more rapid collapse of family life, more family isolation, and the family itself fears him even after divorce. He is more likely to fight at work, walk out on the job, lose more time, and experience less advancement at work.[4]

Etiology of Alcoholism

The etiology of alcoholism is obscure at the present time. It appears that alcoholism is a disease of multiple etiologies involving psychogenic, social, and behavioristic factors, physiologic and hereditary factors, and the pharmacologic characteristics of alcohol itself. Unfortunately, all of the attempts to isolate etiologic factors with the possible exception of certain epidemiologic studies of social factors have been based on the study of advanced alcoholics in some captive situation. Thus, hospitalized alcoholics, imprisoned alcoholics, and alcoholics who have already sought help or have been treated have been extensively studied. Few or no universally characteristic features have been so isolated. Some common characteristics have been reported, but there are numerous conflicting results reported, and in many studies preconceived ideas of what an alcoholic should be like was the hypothesis to be proved. Even if common characteristics were discovered, one is hard put to decide whether these are features of alcoholics per se, or the results of years of heavy drinking. A prospective study similar to the Framingham study of coronary heart disease is needed.

Many psychologic, psychiatric, and psychoanalytic studies have been reported. Common descriptive phrases used to describe the alcoholic personality vary from narcissistic, oral, anxious, and dependent to charming, gracious, cheerful, and spontaneous. The approach seeking psychogenic factors has thus far produced little practical information.

In the sociologic approach there is evidence that certain nationality groups have a higher prevalence of alcoholism than others, with the Jews and Italians having a low prevalence while the Irish and older American group have a high prevalence of alcoholism.[5] In the United States of America alcohol has become a "domesticated drug" and enhances group behavior. Drinking in our society is more acceptable to males than females, and as education, occupational level, and income increases, drinking becomes more acceptable according to one survey.[6]

Alcohol has a deep-seated symbolic meaning and the trend through the ages has been a gradual transition from communal to individual use. It is also important to remember that alcohol is a food having seven calories per c.c. and Horton reports that the alcohol consumption within a cultural group is directly proportional to the subsistence hazard and the availability of liquors.[7]

Three sets of variables operate in a given culture:[8] (1) Dynamic factors—the presence of acute psychic stress, (2) Normative orientation, and (3) Alternate factors—eating for Jews.

In contrasting Jews with the Irish in normative orientation, the Jews feel that drinking has strong religious connotations and is characteristic of Gentiles. Sobriety is a virtue. The Irish dissociate drinking from religious ideals; drinking is not a regular part of family social routines, and the cultural tradition of drinking is for affective reasons, simply to meet adjustment needs of individuals. It appears that social factors are very significant in the etiology of alcoholism.

Heredity may play an important although unknown

part in the etiology of alcoholism. In animal studies, great individuality is noted in the desire to drink. The pharmacology of alcohol is also important in the etiology of alcoholism. The World Health Organization in 1954 placed alcohol intermediately between the addiction-producing drugs and the habit forming drugs.

The best current summary is that psychological and sociologic factors may account for the early initial phase of addictive drinking, but later developments in addictive drinking are more a physiopathologic process.

Effect of Alcoholism on Industry

According to the Yale studies on alcoholism, the direct and indirect costs of alcoholism to industry were designated as follows:

Direct costs are (1) man hours lost through absenteeism and charged to other illnesses, (2) disciplinary time lost, (3) hospital and medical expenses, (4) costs of accidents—an estimated 1500 fatal accidents per year are directly related to alcoholism in the United States of America, (5) disability payments, and (6) premature retirement.

Indirect costs are: (1) work inefficiency—Monday is lost, Tuesday and Wednesday half efficiency, and in regards to women with alcoholic husbands, half efficiency on the job due to worry and anxiety, (2) slow down of team effort if one or more members of the team are working at half efficiency, (3) effect on safety standards, and (4) effect on morale.[9]

Another item should be added to the indirect costs of alcoholism and this is the costs of training a worker, this expenditure being lost if the worker is lost. Dr. Thomas H. Hogshead[10] reports that the DuPont Corporation estimates that it takes $2,000 to train a textile machine operator, $5,000 to train a supervisor, and $25,000 per year to maintain a research chemist who is already trained. DuPont's safety program cost 8 million dollars from 1944 to 1954 and saved an estimated 54 million dollars. DuPont's alcohol program rehabilitated 350 men over a ten-year period and cost less than $100,000. If one considers that each man's training was worth $2,000, the lowest figure given above, $600,000 was saved in retraining expense alone. By dismissing these employes on discovery, a large sum of money would have been lost, and the problem would not have been solved but merely recirculated. Recalling again that there are over two million problem drinkers in industry, 90 per cent being between the ages of 35 and 55 years of age, already trained, and that the best estimate available indicated that each problem drinker loses 25 to 30 days per year as a result of his drinking, alcoholism costs industry a tremendous amount of money and poses a tremendous problem.

A note on statistics is proper here. Most of the studies on absenteeism, accident rates, and sickness payments due to alcoholism are data on alcoholics who by virtue of having many accidents and flagrant absenteeism were discovered as alcoholics. Alcoholics with minor violations in these respects are not discovered. This fact tends to underestimate the total amount of absenteeism and accidents caused by alcoholism and to overestimate the accident and absenteeism rate per alcoholic in industry.

Early Detection of Alcoholics in Industry

Alcoholics, in general, avoid visiting the medical department. They fear discovery and deny their alcoholism. An added complication is a fact stated by Miller:[11] "Peculiar to alcoholism is the manner in which fellow employes, family, supervisors, and at times even the family physician 'cover up' for the alcoholic."

Since etiology is unknown, there is absolutely no basis to suspect a man of being an alcoholic on the grounds of marital status, religion or lack of religion, cultural background, occupational level, specific personality trait, or level of intelligence. No group is exempt from the development of alcoholism. However, people who enjoy many and varied interests are less likely to be alcoholics and if they are, the prognosis for arresting the disease is good.

Milton A. Maxwell[12] conducted a study which is worth describing in some detail. He submitted questionnaires to 406 male alcoholics who were either in the process of treatment or were "cured" or "arrested" cases. Seventy-two per cent of the 406 men were over 40 years of age. They represented all levels of occupation, various sized industries, and all parts of the country, although a majority were from the East and Middle West. Forty per cent represented the manufacturing industry. A summary of the results follows:

The duration of time from the drinker's first recognition that he had an alcoholic problem to the time he first sought help ranged from months to 32 years, with a median of seven years, and of the sample, one-half had a period of four years or more elapse between the time the first symptoms of drinking occurred at work and their seeking help. Two-thirds of the alcoholics had not lost their jobs at the time they first sought help for their drinking problem.

Two-thirds of the sample also realized they were alcoholics and experienced home or social problems before they had on-the-job symptoms of drinking. One-third had on-the-job symptoms of drinking before they themselves were aware of a drinking problem.

Six on-the-job signs of drinking which occurred in 90 per cent of the sample were increased nervousness, hangovers, making mistakes, red or bleary eyes, greater irritability, and hand tremor. However, a large percentage reported only rare or mild occurrence of making mistakes or absenteeism.

In fact, all forms of absenteeism were of low frequency of occurrence with leaving the post temporarily, leaving work early, longer lunch periods, and tardiness reported in that order of frequency of occurrence.

In respect to the earliest signs to appear on the job, hangover was by far and away the most frequently reported. This was followed by morning drinking before going to work, absenteeism, increased nervousness and/or jitteriness, and drinking at lunch time. Thus, all forms of absenteeism occurred early, but the frequency of absenteeism was low during the whole problem drinking period.

Absenteeism was an early sign, but a tremendous effort was made to avoid it. Excessive absenteeism is considered the greatest threat to job security, and loss of a job and income threatens the future possibilities of buying enough alcohol. Morning drinking was a way of handling hangover, and thereby avoiding absenteeism. Even drinking at work will be risked to avoid leaving work early and to combat the signs of hangover.

If H represents *H*angover (symptoms of headache, thirst, jitters, and avoidance behavior); A represents all forms of *A*bsenteeism, B represents alcohol in the *B*lood (aroma of alcohol on the breath, using cover-ups like gum, avoiding supervisors and fellow workers, and mood changes), and P represents *P*hysical signs (red or bleary eyes, flushed face, hand tremors, greater irritability, and deterioration of job performance), then the most common sequence pattern is H or A first, followed by B and P. P is the most common in high status jobs.

Alcoholic workers who are entering the phase of "on-the-job" symptoms will have excessive absenteeism and symptoms of hangover at work. Absenteeism and symptoms of hangover will be combated very early, however, by attempting to maintain a suitable blood level of alcohol during the working hours by titrating alcohol intake against symptoms. This attempt is made by drinking before going to work, during the lunch hours, or at the job place. Consistently maintaining a satisfactory blood level during an eight-hour work day is impossible and sooner or later physical signs appear.

It is obvious that companies establishing programs of early detection of alcoholics must rely very heavily on their supervisory staff's ability to detect alcoholic signs in their workers. Supervisors must be well-tutored in the symptoms and signs of alcoholism to be effective. This is the responsibility of the medical director. Also general education of all employes is needed to drive home the point that the best way to help an alcoholic is to have him seek medical aid, since he has a disease. To hide or cover up for the alcoholic is actually doing him a grave disservice.

An employe suspected of being an alcoholic should be referred by the supervisor to the medical department where a definitive diagnosis may be made by the industrial physician. This diagnosis must be based on a history with an intensive psychiatric-type interview, a thorough physical examination, and very often a conference with the patient's close friends and spouse is necessary to confirm the diagnosis.

Handling of Detected Cases and Company Alcohol Control Programs

Before initiating a program of alcohol control, top management must be made aware of the tremendous costs alcoholism imposes on industry in inefficiency and impaired health (refer to "Effect of Alcoholism on Industry," page 62).

Most successful company alcohol control programs have certain common features. A working *definition of problem drinking* must be selected. The phrase "problem drinker" is more acceptable than "alcoholic," and should be used. An example of a satisfactory definition is: "An employe whose work is materially reduced in efficiency and dependability because of excessive drinking."

Direction of the program may be assigned to the Medical or Personnel Department. The medical director, however, should be in full charge of the education program, especially of the supervisory staff.

A definite *company policy* must be formulated and enforced. Every problem drinker is put on probation. This period may vary from three months to one year. During this period, the problem drinker must recognize his problem and seek help or he is fired. This threat of job loss is an indispensable facet of the treatment. Few, if any, problem drinkers decide to stop drinking unless some pressure is put upon

them. Lemere[13] found that the threat of losing one's job was one of the strongest motivating sources, second only to endangering one's physical and mental health. I believe that threat of job loss is the most powerful motivation factor for reasons given above. Prognosis depends on motivation and is hindered by denial and projection on the part of the patient. Threat of job loss combats denial and projection.

Education of the supervisory staff is all important and the degree of knowledge which the supervisors have will directly equate to the success of the program. Supervisors must be educated in detection and counseling of problem drinkers. They must approach the problem drinker with understanding and attempt to motivate him to seek treatment. If company policy is to fire problem drinkers on detection (archaic thinking), supervisors tend to protect their workers, but this is true even with a good alcohol control program. This is why education is so important. Furthermore, problem drinkers tend to keep their work up and after all, anyone can have a bad day. Detecting problem drinkers is difficult and training in detection is paramount.

Education of the general employe staff is also very important. Stress is placed on the phrase, "Alcoholism is a disease, and must be treated, and the earlier the better." Alerting the general employe group checks the disease in the early stages. Drinking is no longer an excuse for poor work performance. Major cases are more easily recognized and the minor cases find it increasingly more difficult to keep their drinking secret.

Referral is made to the *Medical Department* by the supervisor. It is the duty of the industrial physician to diagnose the case definitively and to rule out underlying physical or mental disorders. It is the responsibility of the medical director to be fully acquainted with all local facilities and resources which handle alcoholic problems. The cost of the program is minimal when full use is made of local community facilities. The following sources will prove beneficial:

National Committee on Alcoholism
2 East 103rd Street
New York 29, New York (56 local affiliates)

Alcoholics Anonymous
P.O. Box 459
Grand Central Annex
New York 17, New York

Pre-referral counseling should be done by the medical director. A study by Trice[14] on aspects of Alcoholics Anonymous affiliates offers useful suggestions on pre-referral counseling. The physician attempts to reduce barriers to affiliation with AA in the following ways:

1. Determine whether the patient can share basic emotions with others. However, it is to be remembered that losing one's drinking friends is an added stimulus to seek treatment. The responsibility of the physician in this respect is to diagnose the asocial personality disorder, and to recommend treatment on an individual basis.
2. Dispel any thought that the patient can quit by will power alone or that his family can cure him.
3. Push Alcoholics Anonymous as being sincere in living up to its program and assure the patient that AA members are really problem drinkers. Explain what AA is and what to expect (although this can be done by an AA interviewer, and this is good practice). Stress that all social classes belong to AA and not just "bums." Encourage participation in the "before-and-after" meetings and informal get-togethers. Explain that therapy is on an informal, spontaneous group basis.
4. Stress that drinking troubles are greater than drinking pleasures and finally encourage the patient to take his wife to the meetings.
5. The patient is *referred* to Alcoholics Anonymous. I believe that all programs should be closely knit with AA. They have an outstanding record for "cures," better than all other methods combined. The patient should remain with AA at least during the probationary period, except in specially indicated cases in which referral can be made to other facilities.

Initial and subsequent interviewing is important. Develop the focus that the patient is suffering from a disease process. Develop self-respect in the patient by treating him with respect. Stress the hope of cure. Whether or not the alcoholic admits his disease, alcoholism as a disease should be discussed with the object of educating the patient and with the hope that the patient will identify with the disease.[15] Try not to activate anxiety which may lead to more drinking. Model yourself after Alcoholics Anonymous: "They do not condone alcohol, yet are neither punitive nor contemptuous."

In summary, all company alcohol control programs should consist of the following eight basic components:

1. A written definition of alcoholism
2. A specified director of the program

3. A specified company policy
4. Supervisors' education
5. Employe education
6. Definitive diagnosis by the medical department
7. Pre-referral counseling
8. Referral to Alcoholics Anonymous with periodic follow-up by the medical director.

Summary

Alcoholism is defined and described in its various types and patterns of drinking. Etiology is discussed. The effects of alcoholism on industry are listed, and its costs estimated. Early detection of the alcoholic in industry, and the handling of detected cases have been studied in detail, as was company alcohol control programs. The niceties of personal medical interviewing are exposed.

The industrial physician will find the "Lost Work Tr-end" of far greater significance than the "Lost Weekend."

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Scientists Find 20 Distinct Virus Forms in 35 Common Cold Cases

The "multiplicity" of virus forms causing the common cold helps explain "the riddle of the recurring cold," but complicates the search for an effective vaccine.

So says a team of physicians and researchers in a report, published by The American College of Physicians, on 35 cold viruses, isolated from studies of respiratory conditions in 403 children and adults. Twenty distinct types of virus forms—referred to as coryzaviruses—were recognized.

Writing in the October 1962 issue of the *Annals of Internal Medicine*, the scientists stated that the recovery of viruses or groups of viruses in tissue culture from cases of common cold "presents what appears to be a breakthrough" in determining the cause of the common cold in adults and of mild colds as well as lower respiratory tract infections in children.

The report, by Joseph Stokes, Jr., M.D., Philadelphia, Maurice R. Hilleman, Ph.D., West Point, Pa., and five co-authors, said that, with one exception, "there did not appear to be a preponderance of any particular virus type among the cases studied.

"The multiplicity of (virus forms) and the striking lack of cross-reaction between types go far toward explaining the riddle of the 'recurring' common cold. They serve to emphasize also the difficulty which is likely to be encountered in providing adequate 'broad-spectrum' coverage in polyvalent cold virus vaccines."

The cold viruses were recovered from 263 children with respiratory conditions seen by members of the Children's Hospital staff and from 140 adult patients with respiratory diseases in the Merck & Company, Inc., plant dispensary, Rahway, N. J. Eighty-one controls were used at the hospital and 48 at the dispensary.

Meconium Peritonitis

Case Report

Norris Gilfillan, M.D.
Thomas R. Kirk, M.D.
Petoskey, Michigan

MECONIUM peritonitis is of relatively uncommon occurrence[1] found only three times in 108,744 live births from July, 1937 to July, 1952 at Charity Hospital, New Orleans. The cause for the peritoneal contamination is not wholly agreed upon. Perforation may be due to: (1) congenital obstruction, (2) acquired obstruction, (3) traumatic perforation without obstruction, (4) spontaneous perforation. [2,4,6] The majority, however, would seem to be secondary to congenital gastrointestinal malformations, stenosis and atresia leading the list, prognostically less severe[5]. Meconium ileus with subsequent proximal perforation likewise accounts for a number of cases of meconium peritonitis, the prognosis here being very poor.[3]

The size of the perforation and magnitude of the insult regulate the clinical picture. Infants rarely develop leakage before the fifth or sixth month since peristalsis is not present prior to this time. A small, slow contamination started in the early third trimester of gestation may be recognized as flocculant calcific deposits seen on x-ray examination. On the other hand, a sizeable outpouring of meconium may present an acutely obstructed and gravely ill baby, as seen in the reported case. The microscopic picture reveals fibrinous exudate accompanied by cellular infiltrates, fibroblasts, monocytes, and polymorphonuclear cells, as well as amorphic and eosinophilic debris. Calcific deposits may be found scattered throughout the coagulum as well as bile stained macrophages. The reported

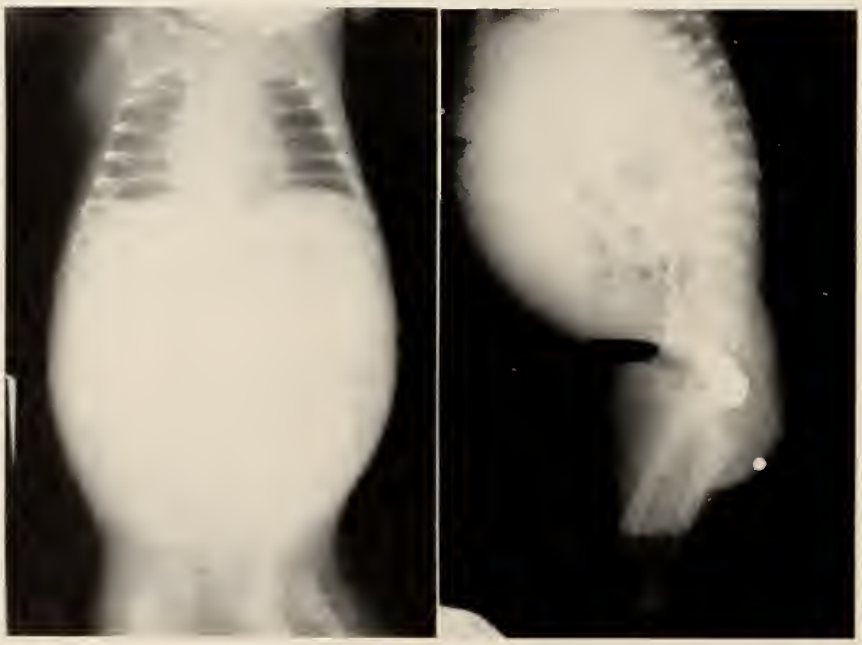


Fig. 1. *(left)* Free air under right hemidiaphragm.

Fig 2. *(right)* Patent anorectal canal. Free air again demonstrated. Large volume of free abdominal fluid anterior to small bowel.

case shows all the changes except the calcific deposits due to the short duration, presumably.

Case Report

D.A.W. (No. 91608), a ten-hour-old male infant, was admitted to the newborn nursery in moderate respiratory distress and with a distended abdomen. The child was the product of an apparently uneventful gestational period. The mother had had no prenatal care, however. The mother had had toxemia with a sibling born one year previously, and this infant was apparently normal.

During the delivery, the referring physician believed shoulder dystocia to be present initially because of the extremely slow progress of labor. Low forceps were used, and as the baby was delivered, an enlarged abdomen was noted and thought probably to be the impeding factor.

Following delivery, the child was reported to have a weak cry and was slightly cyanotic in oxygen. The abdomen continued to enlarge, respirations becoming slowly more rapid. No meconium was passed per rectum and no vomiting had occurred prior to referral.

On arrival at Little Traverse Hospital, the infant's abdomen was rather markedly distended with a bluish cast apparent over the abdomen. Respiratory effort was rapid, but not labored, and the child was slightly cyanotic. Examination revealed a normal infant with a fluid-containing, distended abdomen and a patent distal anal canal.

Laboratory and x-ray studies were carried out with the following results: Hemoglobin 21.2 gms, hematocrit 64, WBC 19,100, differential—Meta 4, bands 21, neutrophils 53, lymphocytes 22. Chest radiograph was negative for evidence of cardiovascular or pulmonary disease. Abdominal radiographs in upright and inversion positions (the inversion film being taken with an aqueous contrast media) revealed free air and considerable fluid lying anterior to the small intestine. The latter views showed free passage of contrast media well into the sigmoid colon.

At approximately 15 hours of age, the baby was operated on under general ether anesthesia. As the abdomen was entered, a measured 250 cc. of greenish, murky meconium fluid was removed. A culture of this material was taken. Heavy meconium plaques incased the small bowel completely. Perforation was found in the distal descending colon almost at the iliac crest on the lateral aspect. The 3-mm opening was round and smooth. The perforation was closed with several interrupted No. 0000 silk sutures. The abdomen was irrigated with warm saline to remove as much meconium as possible. The abdomen was then closed.

The abdominal wound culture was negative at 24 and 48 hours. The white blood count dropped to 8,950, with a continuing shift to the left. The urinary output was good. On the sixth postoperative day, the first meconium was passed per rectum. The next three weeks were stormy with intermittent obstruction and vomiting which necessitated parenteral feeding and gastrointestinal suction. Weight gain was finally initiated one month postoperatively, and the patient was discharged two weeks later approximately at birth weight.

This patient entered the hospital initially with a delivery problem secondary to an enlarged abdomen. Perforation of the distal descending colon, with meconium peritonitis, was found. No congenital gastrointestinal abnormality could be found as causative factor in the perforation. Meconium ileus secondary to mucoviscidosis was not found. Trauma may be indicated here; however, the regularity of the perforation site would seem against this. The possibility of ulcer or diverticulum, of course, cannot be ruled out. The child survived the stormy period of intermittent obstruction and was discharged at six weeks of age.

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Responsibility in Medical Science

The medical scientist, until recent years, was unabashed in his aim to improve the lot of man. He made no claims to the pursuit of science for its own sake. His was not a search for human betterment regardless of how basic and pure the machinery of his research might be. Today, he is rather ashamed to have these thoughts for fear that he will be stigmatized by "true" scientists and so automatically lowered in the cruel hierarchy of pigeonholes. Clearly, the time has come for medical science to set itself apart, from the dehumanizing trends in science as a whole, to reaffirm its noble purpose in the service of man. The medical scientist must unflinchingly share the physician's high calling. If he renounces it, he degrades not only his science, he degrades himself. (Reprinted in part from Canadian Medical Association Journal article by J. V. Basmajian, M.D.; 86:985, 1962)

Emergency Response to Potential Suicide

Robert E. Litman, M.D.
Beverly Hills, California

THE PURPOSE of this paper is to report some strategies and techniques for handling emergency calls from or about suicidal persons, drawing on the experience of the Los Angeles Suicide Prevention Center with approximately 1,000 such calls. No attempt will be made to review exhaustively all aspects of suicide, but the following questions will be considered: What are potential suicides? How is the emergency aspect evaluated? What can be done?

What Are Potential Suicides?

The essential nature of suicide is not clearly understood. It is not a disease or a pathologic process. Rather, suicide is an event, the culmination of many different processes. The term "suicide" itself, has a number of different uses and ambiguous meanings. The term "committed" suicide indicates a death. In 1958, there were approximately 20,000 committed suicides in the United States; 1,000 in Los Angeles and 747 in Michigan. Committed suicide is defined by the practices of county coroners or their equivalent, who certify the mode of death. Since these practices vary greatly from county to county and from country to country, one should be cautious about interpretations of trends based upon ordinary coroner's statistics.

Retrospective studies of cases of committed suicide have revealed that these persons usually went through a preliminary prodromal phase during which the suicide victim revealed his self-destructive intention. They threatened verbally to commit suicide, or they talked about suicide, or they had made recent suicide attempts, or they showed certain specific behavioral changes (for example, a sudden increase in barbiturate and alcohol intake, or the development of a depressive syndrome). These persons were potential suicides before death. Living persons who manifest such behavior are potential suicides. Such people may or may not represent emergencies.

Some persons indicate that they are potential suicides by making a suicide attempt. This term is defined by physicians thus: An action which simulates committed suicide and brings the patient into contact with a physician is defined as a "suicide attempt." Surveys indicate that there are approximately eight suicide attempts for each committed suicide in the United States. Approximately 5 per cent of the persons who make suicide attempts eventually commit suicide. No one knows how many potential suicide situations there are in proportion to each committed suicide. Probably there are at least 25.

Thus, in a rough way, we can define "potential suicide" as a situation in which one person, called the victim or the patient, communicates to another person, called the listener or the rescuer, that he is overly close to committing suicide, and it registers in an uncomfortable way with the listener. We can estimate that such a situation occurs at least 500,000 times a year in the United States.

The person who receives a suicidal communication may or may not respond to it. The recipient may be a spouse, relative, friend, or someone whose occupation brings him into contact with people in trouble; for example, police officers, bartenders, lawyers, teachers, social workers, nurses, or physicians. In Los Angeles, anyone may call the Suicide Prevention Center, a research and community service project of the National Institute of Mental Health, administered through the University of Southern California, for information, evaluation, consultation, and an appropriate referral, on questions concerning suicide prevention.

The professional person's role in answering such emergency consultation requests can be divided into three phases: First, he obtains necessary information; then he forms an evaluative judgment of the situation; and finally, he recommends appropriate action. He may, for example, recommend immediate hospitalization for a very serious case; or he may interpret the suicidal communication as having low lethal potentiality and recommend no special treatment. Frequently, the consultant makes arrangements for additional evaluative interviews for the prospective patient, with the aim of developing a more definitive treatment plan.

How Is the Emergency Aspect Evaluated?

As a guide to interviewers working under emergency conditions, the Suicide Prevention Center uses the following short schedule for assessment of self-destructive potentiality:

I. *Case History: Factual*

- (A) Age and sex
- (B) Onset of self-destructive behavior: chronic, repetitive pattern, or recent behavior change? Any prior suicide attempts or threats?
- (C) Method of possible self-injury: availability, lethality?
- (D) Recent loss of loved person: death, separation, divorce?
- (E) Medical symptoms: history of recent illness or surgery?
- (F) Resources: available relatives or friends, financial status?

II. *Judgmental-Evaluative*

- (A) Status of communication with patient
- (B) Kinds of feeling expressed
- (C) Reactions of referring person
- (D) Personality status and diagnostic impression

Case History: Factual

Age and Sex.—The age and sex of the patient are generally the first items of information to be considered. These two facts provide a framework within which the emergency classification and appraisal of self-destructive persons can proceed. At all ages, suicidal communications from males arouse more concern than similar communications from females, and, in general, the older the person, the more serious is the self-destructive potentiality. Moreover, the danger increases with age much more for male than for female patients. We have rarely encountered a nonlethally intended suicidal action in a man over 50 years of age. Thus, a self-destructive communication from or about a person in this age and sex group immediately raises suspicion of a high-risk situation, and the burden of proof that this is not an emergency rests upon the other data that can be obtained.

By contrast, the group of young women, aged 15 to 35, provides the largest number of self-destructive nonlethel communications and suicidal attempts, i.e., the least number of completed suicides. In this group, the goal of influencing another person's behavior, with little or no intention to die, is more often prominent. Other factors involved in the lower emergency danger rating for women are their choice of less violent methods of self-injury (pills rather than guns) and their greater willingness to communicate (ask for help and accept it). In the middle-aged and older female group, suicidal threats and attempts tend to become more serious.

Onset of Self-destructive Behavior.—As a general rule, the more acute and precipitous the onset of the self-destructive behavior, the better the ultimate prognosis and, paradoxically, the greater the need for active intervention. Thus, a history of recent personality change combined with a history of recent actual suicidal attempts is a major danger signal for the immediate future. If there has been a pattern of repetitive self-destructive behavior over a long period of time, the eventual outlook may be extremely pessimistic, especially as the potential victim grows older and the condition gradually grows worse. However, in such chronic cases, although emergency intervention may be necessary for the immediate situation, it usually has no lasting effect, and a more gradual long-term rehabilitation plan must be formulated in addition. A crucial point in the evaluation is whether the person with a chronic, repetitive self-destructive pattern has completely exhausted his emotional resources (see section on Resources).

Method of Possible Self-injury.—The method of self-injury proposed by the patient sometimes reflects the degree of emergency. In general, a specific choice of time, place, and method for the proposed suicide is a serious indication, but if the method is aspirin ingestion or cold pills, the emergency is dissipated. By contrast, the person who owns a gun and proposes to use it against himself should be the object of immediate emergency efforts, if not toward him, at least toward removing the gun. Similarly, ideas of jumping from a high place should be taken more seriously and may call for questions as to where the person is, et cetera. Nearly all pills used to produce sleep can be lethal in large amounts, but the rapid-acting barbiturates, such as pentobarbital and secobarbital, are by far the most effective for suicide.

Recent Loss of Loved Person.—Many suicide attempts, especially in young persons, occur after the separation from a spouse or a loved one. In these circumstances, self-destructive behavior is often undertaken with ambivalent feelings. The wish to die is balanced by a wish to live and to be rescued and reunited with the loved person. Frequently, these suicide attempts are successful as a form of adaptational behavior in that they do serve to bring the loved person back. On the other hand, in many of these gambles with death, death wins. When there has been a definite loss of a loved person, such as a spouse, parent, child,

lover, or mistress, within the previous year (by death, divorce, or separation), the potentiality for self-destruction is increased. Certain persons, such as some widows of ages 40 to 60 who have been extremely dependent on their husbands, display exaggerated mourning and grief reactions associated with strong self-destructive urges.

Medical Symptoms.—A history of recent hospitalization or medical consultation may indicate increased self-destructiveness, especially in older persons. Medical conditions most often associated with suicidal reactions are psychosomatic diseases, polysurgery, malignant tumors, and various symptoms associated with depression. Some indicators of depression are anorexia, weight loss, sleeplessness, fatigue, impotence, loss of sexual desire, and hypochondriacal preoccupation, especially cancerophobia. When a chronic debilitating disease such as cancer actually exists, suicidal reactions tend to be precipitated by incidents that the patient interprets as rejection from family and physician.

Resources.—Often the attitudes of spouse, relative, or friend may mean the difference between life or death for persons involved in symbiotic relationships. A consultant wants to know who brings the patient to the attention of helping authorities and why? Are there relatives in the picture? Is there a history of solidarity with spouse, relatives, or friends? Or, contrariwise, is there a history of instability, constant ambivalent relationships, desertion, and distrust? Financial resources need to be included in the evaluation, as these determine to some extent what types of treatment are available. A recent loss of job or sudden drop in financial status may constitute a traumatic loss to certain persons, especially middle-aged men and career women. Persons who have a lifelong history of indirect self-destructiveness, as illustrated by unstable interpersonal relationships, alcoholism, impulsivity, and hostile dependency, often reach a crisis in the fourth or fifth decade when they find that they have exhausted themselves financially and interpersonally; they are, so to speak, emotionally bankrupt. After a long pattern of suicidal gestures, this may be the point when such persons actually do commit suicide.

Judgmental-Evaluative

Status of Communication with Patient.—For a person struggling with strong currents of self-destructiveness, the life line is one of unbroken communication with other persons. When a patient is able to express his troubled feelings and cry for help, the self-destructive danger may be high, but it is never so extreme as when the patient has given up and withdrawn and is no longer communicating. A warm, receptive, hopeful, encouraging, responsive attitude by the consultant will help to keep the communication line intact. Repeated telephone connections with the patient can help to weather a short period of crisis. Usually, an emergency self-destructive situation is ominously foreshadowed by a break in the communication, cancelled appointments, unanswered telephone calls, and silence.

The most perplexing problem is presented by those self-destructive persons who reject offers of consultation, assistance, or therapy. With a life at stake, how can we help someone against his own will? This represents a most complicated medical, legal, and ethical problem, and this is not the place to examine the issue in detail. However, in a limited number of experiences with this situation the SPC staff has found that often the hostile attitudes, objections, and resistances of the potentially self-destructive person were relatively superficial and would melt away when exposed to sympathetic, firm, consistent, and coordinated helping efforts.

Kinds of Feelings Expressed. — Typical presuicidal communications include verbal statements such as "I am tired of life," "I mean to end it all," "my family would be better off without me," or "soon I won't be around." On a behavior level, efforts to put business and social affairs in order, the making out of a will, and unusual preparations as if for an absence may have a similar significance. Suicidal threats designed primarily to taunt or punish the recipient or to gain a distinct goal or advantageous objective (for example, to force a marriage or obtain a therapeutic abortion) carry a relatively low emergency lethal valence. The affective state associated with these communications should be evaluated. The most serious suicidal potential is associated with feelings of helplessness and hopelessness, exhaustion and failure, and the feeling "I just want out." A combination of agitation and confusion, however, particularly in a person who has had a previous psychotic episode, may constitute an emergency. When the predominant feeling is one of frustration, anger, or rage, without overwhelming confusion, the lethal danger is generally somewhat less.

Reactions of Referring Person. — If the referring person is a spouse, relative, friend, or other lay person, a number of possible reactions require evaluation.

First, are there indications of a close and ambivalent symbiotic relationship and, if so, is it possible that the referring person is actually also disturbed? Does the referring person's attitude reflect a need to have a sick, dependent partner leaning upon him? Is there an attitude of rejection and a desire to get rid of the potentially suicidal person? A defensive, paranoid, rigid, punishing, moralistic, or hopelessly dependent attitude on the part of the referring person indicates that little help can be expected from that source, although attempts should be made nevertheless to secure as much cooperation as possible. It is generally encouraging when the referring person expresses sympathy and concern for the patient, together with an admission of his own sense of helplessness in the situation and need for assistance. Often the referring person with guidance and advice, can be a source of strength and support in the emergency situation.

Professional persons sometimes express an exaggerated or disproportionate degree of anxiety over a relatively mild self-destructive communication from a patient or client. Reassurance from a consultant will often encourage such persons or agencies to proceed with their own appropriate techniques. On the other hand, some emotional reaction is expected from the referring person, no matter what their professional training and experience, because emotions activated by suicide go very deep in human psychology, well beyond the usual concept of countertransference. This also applies to calls from professional psychotherapists, whose requests for consultation bring up special problems. When a referring psychotherapist indicates no feelings of personal concern about his potentially self-destructive patient, one wonders whether the therapist's judgment and insight can be relied upon for purposes of evaluation. If the therapist recognizes feelings of annoyance or irritation with the patient in himself and can discuss them with the consultant, this in itself reduces one's feeling about the immediate suicidal potentiality of the patient. If the psychotherapist reports honest feelings of helplessness in himself and a breaking off of communication between himself and the patient, then it would appear that an emergency situation has developed and it is time for some sort of active intervention. In these situations, the source of the difficulty may be some specific countertransference problem in the therapist, which can be resolved by a supervisory consultation. Often the SPC has provided, in addition to such consultations, needed practical information about community resources, available clinics, methods of hospitalization, commitment procedures, etc.

Personality Status and Diagnostic Impression.— Much of the information that might be subsumed under this heading has already been discussed. What should be re-emphasized is the importance of evaluating the possible presence of psychotic thinking and severe depressive effect. If either of these indicators is present, and especially if combined with alcoholism, the question of emergency hospitalization must be seriously considered. One asks about previous hospitalization for mental illness and looks for the various symptoms of disordered thinking (confusion, disorientation, delusions, disturbed body image, etc.). One wants to know, in addition, about past periods of elation or depression and the extent of the depression. The course and outcome of previous psychotherapy efforts should be ascertained. A previous pattern of failure in therapy is a danger signal.

What Can Be Done?

The most important therapeutic maneuver that is going on throughout the evaluation consists of establishing, broadening, and maintaining contact with the patient, and re-establishing his communication with the rest of the world. Additional guide-lines for the interviewer are these: The patient needs psychological support. He has lost his feeling of being a worthwhile individual and needs help in reconstituting his sense of identity. He needs stimulation toward action.

As one maneuver which tends to carry out all of these aims, we try to involve the other members of the family, or friends and available community resources, in the formation of a cooperative treatment plan for the patient. Very often the cooperation or non-cooperation of the person closest to the potential suicide makes the difference whether the patient can be treated outside the hospital or in the hospital. For those patients who are evaluated as most seriously suicidal, or when, temporarily, there is an extremely high risk of suicide, there is no substitution for the hospital, most preferably a psychiatric hospital. The patient must be hospitalized, not only to protect him against suicide, but because also that is where the appropriate therapeutic modalities are located. I am thinking of milieu therapy, appropriate drugs, and particularly electric shock treatment when it is indicated.

During the interview, *psychological support* is transmitted by a firm and hopeful attitude. We convey the impression that the problem which seems to the patient to be overwhelming, dominating his entire personality, and completely insidious, is commonplace and quite familiar to us and we have seen many people make a complete recovery. Hope is a commodity of which

we have plenty and we dispense it freely. We try to give a structure of interpretation and understanding regarding what is wrong, organizing the problem as logically as possible and stating it clearly back to the patient. In this connection we are always completely honest about who we are, what we are doing, and why we are doing it. We use the word "help" in many different contexts. We use tranquilizing and energizing medications rather freely, always with a hopeful and optimistic attitude.

In our experience, the potentially suicidal person is overwhelmed by a feeling of failure and often paralyzed into immobility, relieved in some persons by sudden impulsive spasms of action. Often the suicidal action is a desperate attempt to regain the ability to act. Therefore, we try to *stimulate toward action*, meaning a series of planned and organized actions which the patient can be expected to negotiate with a degree of success. For instance, just coming to the Suicide Prevention Center for consultation is such an action. From the minute the patient arrives, he is given a series of tasks to perform. During the interview there is an implication that this interview itself is an action toward improvement made by the patient. He is given simple paper and pencil psychological tests to perform, and our attitude conveys the idea that this involves important action toward solving his problems. Frequently the patient is asked to make a telephone call at a certain time the next day to report how he is doing.

We obtain the history of the patient and his problem, not only with an eye toward collecting facts to evaluate the strengths, weaknesses, and resources of the individual, but also to *re-establish his identity* in his own mind, recreating, during the interview, a sense of himself as a person having existed in the past and having a future. During the interview we remind the person, by our questions, who he is and what he is. He reviews his identity as a husband, job-holder, father, citizen, et cetera. At the same time, questions about his present problem and situation are aimed at widening his view of the world and reminding him of alternative possibilities to explore, and of possible additional solutions to what appears to him to be a dead end.

About 15 per cent of the calls to the Suicide Prevention Center have involved such seriously suicidal potential that we have arranged hospitalization for the patient. Of the remainder, about half feel that their problem has been handled satisfactorily by one or more contacts with the Suicide Prevention Center. In the others, the final treatment plan includes a referral for some sort of counselling, family therapy, or other form of psychotherapy. While there are a substantial minority of persons who repeatedly become potential suicides, for the majority of persons the potential suicide position is transitory. When they recover, it does not necessarily ever recur again.

Sees Too Little Time For School Physical Fitness

The greatest weakness in the average high school physical education program is the lack of time. Physical education classes often are used largely to plug gaps in the academic schedule, with little regard for the needs of the student. As a result, the periods are too short, or too infrequent. We recommend (on the advice of 19 leading medical and educational organizations) at least 15 minutes of vigorous activity daily for every student. In addition, there should be time for changing clothes and taking showers.

Physical education must become as much a part of the curriculum as science, history and language if education is to achieve its stated objective: "Sound minds in sound bodies."

It is just as important to use time properly as it is to have it scheduled. Some sports and games do not provide enough vigorous physical activity. Others encourage students who are already fit to dominate the action, while those who need exercise most merely stand back and watch. There should be more emphasis on activities which involve the entire class, and which develop strength, stamina and skill.

There is still another common fault: the reservation of enthusiastic support, good facilities and topflight instruction for those who need them least—the varsity athletes. Every student, boy or girl, should have the opportunity to participate in a program which will help to achieve and maintain physical fitness.—CHARLES B. (BUD) WILKINSON, *Chairman, President Kennedy's Council on Youth Fitness.*

Introduction to the History Of Human Sperm Motility

Georg Sillo, M.D.

Frankfurt, Germany

THE BASIS of every science is the human being. The human being cannot be created without the existence of spermatozoa. The "homo sapiens" is several thousand years old; however, the human spermatozoon was discovered only in the 17th century. The discovery of human spermatozoon was simultaneous with the discovery of human sperm motility.

History

About 400 B.C., Demokritos supposed that fertil ization is due to moving "worms," but medical science had to wait until 1677 when a young student of medicine, Johannes Ham, discovered the movement of human spermatozoa under the microscope. Ham demonstrated to Leeuwenhoek the moving sperm on a slide. It was very fortunate that he had trust in Leeuwenhoek's greater experience and knowledge. Leeuwenhoek affirmed Ham's discovery and informed the Royal Society in London of this fact in November, 1677:

"Mr. Ham visited me. He brought with him, in a small phial, the spontaneously discharged semen of a man who was suffering from gonorrhoea; saying that, after very few minutes he had seen living animalcules in it, judging these animalcules to possess tails and not to remain alive above twenty-four hours. This gentleman also reported that he had noticed the animalcules were dead after the patient had taken turpentine. In the presence of Mr. Ham, I examined some of this matter which I have introduced into a glass tube and saw living creatures in it, but when I examined the same matter by myself after the lapse of two or three hours, I observed that they were dead."

In this report there is not only the description of moving animalcules in the semen but also that these die after a certain time and that the acute gonorrhoea does not inhibit motility.

From the Service for the Treatment of Male and Female Fertility Disturbances, Frankfurt/M, Germany. Head: Georg Silló, M.D.

Lecture at the Ninth International Congress for the History of Sciences, in Barcelona, Spain, September 4, 1959.

Leeuwenhoek as the first semen explorer declared that: (1) the semen remain in testis vigorous for four hours; (2) additional movements may be obtained if eggwhite is added; (3) he observed the passage of the spermatozoon in the cervix, uterus and tube (in dogs and guinea pigs); (4) the cause of the male infertility is the lack or the short life of the sperm; (5) the velocity of sperm is 4 to 5 inches in a half hour.

Another hundred years went by after Leeuwenhoek's statements before something interesting was added to our theme. It was in 1758 that Ledermüller observed the spermatozoon tail and described it as having frog-like movements. Haller reported in 1778 the rotating motion of spermatozoa. The head movement was discovered by Lamperhoff in 1835.

In 1841, Kölliker who had the greatest influence on subsequent explorers, declared that the sperm transportation is brought about in the uterus not only by self motility of spermatozoa but that other factors are also involved. He already considered the motility of the spermatozoon as the phenomenon of vitality. Vitality depends on the chemical combination. Benda, in 1887, postulated that motility is started by an irritating apparatus. According to his investigations, this apparatus is the posterior centrosome, while Boveri in the same year (1887), said that the anterior centrosome plays an important role in the fertilization. Jensen discovered the spiral body and the endring of the middle piece in 1879. Ballowitz went even further when he described the fibrillary structure of the axial filament in 1888.

According to Ankermann (1854), the motility should be considered as swinging motion resulting from the diffusion stream existing between the spermatozoon cell and the surrounding fluid. Lott (1872) returned to the principle of spontaneous movement. Ducelliez (1854) described his hypothesis from the suction effect of the uterus by libido, and Heap (1898) proved that the greater part of the semen is transported into the uterus as a result of this effect.

Vauquelin (1791) wrote the first treatise on the

chemical composition of the semen. Later, Quatrefages (1890) dealt intensively with the chemistry of spermatozoa, particularly he described the marked toxicity of copper, lead, and mercuric salts on the motility. Ankermann (1854) added to our knowledge on motility his systematical chemical observations.

Factors influencing motility were already differentiated by Haller (1778) as chemical (poisons) and physical (cool-warm) factors, but Funke and Naegeli after 78 years still could not agree as to whether the cause of motility is physical or osmotical (1856).

Spallanzani (1795) realized that sperm motion is destroyed by acetate acid and supposed that the seminal fluid contains the inducive capacity to produce the movement of spermatozoa. Donné (1837) observed the influence of different fluids (milk, spittle et cetera) on the movement. The investors of environment theory are Moleschott and Ricchetti (1855). Percy (1861) published the first result of preservation in dextrose solution.

Newport (1853) stated that sodium chloride and various other sodium and potassium salts are able to stimulate or inhibit the sperm motility according to concentration and specific experimental conditions. However, if exposure to the acidity has not been unduly long, it is possible to resuscitate spermatozoa by alkalinization (Engelmann, 1868).

The frequent cool-temperature effect on preservation and particularly on revival, was first mentioned among the physical factors by Spallanzani. He wrote that freezing (in snow) does not necessarily kill the sperm but reduces it to a state of "lethargy" from which it recovers when the higher temperature returns. Later, Mantegazza (1866) put on record a seemingly definitive theory.

These were the data of the human sperm motility until the twentieth century. The science of spermatology improved significantly from that time to our days.

Frankfurt/M, Germany
Fürstenbergerstr. 147

JAMA Comments on Doctor Beaumont

Members of the Michigan State Medical Society are always interested in the editorial comments in other medical journals about William S. Beaumont, M.D. An interesting editorial about Doctor Beaumont appeared in the November 24 number of *The Journal AMA*.

The article, which makes several references to MSMS, points out in part:

"A memorial monument dedicated in 1900 by the Michigan State Medical Society is located facing the parade grounds in restored Fort Mackinac, looking out over the straits," and "The American Fur Company's retail store on Mackinac Island, where Alexis St. Martin was injured, has been restored by the Michigan State Medical Society as the Beaumont Memorial."

The editorial opened with the interesting comment:

"No more famous doctor-patient relationship is recorded in medical or lay literature than William Beaumont's medical and surgical care of Alexis St. Martin, implemented by sympathetic and charitable ministrations to this French Canadian voyageur."

An evaluation of the work of Doctor Beaumont is made by the editorial:

"The importance of Beaumont's observations to experimental physiology and, in particular, physiology of digestion was that they formed a basis for studies by well known physiologists at home and abroad, such as Carlson, Cannon, Pavlov, Muller, and Bernard. The experimental findings soon were quoted in texts and treatises in America and in Europe, giving Beaumont full credit for the original observations. At the eighth International Physiological Congress, held in Boston in 1929, Beaumont's book was reprinted and presented to each member of the Congress as a souvenir of one of America's great contributions to physiology."

Component Societies Serve with Distinction

Most of the component medical societies have changed officers as the new year starts. We offer our sincere "best wishes" to the incoming presidents and their new administrations, and quickly add our "grateful thanks" to the outgoing presidents and their fellow officers.

Perhaps 1962 was the busiest year for the component medical societies. Their annual reports of community service projects and postgraduate education are impressive. And in addition this past year, these societies chose to stand up and be counted during the King-Anderson struggle. The AMA and MSMS can help to provide leadership and plans, but it is up to the individual doctors in the component medical societies who must actually do the work and tell the story.

It is always stirring to read the special messages of the outgoing presidents in their Medical Society Bulletins. Many of them assess the challenges facing medical organizations today with great foresight. One of the current messages especially registered with us, as this outgoing president wrote:

"No one could hold this post without gaining renewed pride in our profession and new faith in the integrity and competence of our members. And we can point with pride at the caliber of new members we have attracted. I am proud, too, of our postgraduate training program."

Those comments could be made without exception across the State of Michigan, as the component medical societies continue to measure up to their responsibilities and opportunities.

Blue Shield and the Aged

Are the physicians of Michigan providing good medical care for the state's senior citizens?

This question is in the limelight presently because suggestions to "let the government do it" in terms of health-care financing and health-care assistance for the aged have filled the air. They have filled it with more heat than light; more emotion and distortion than fact.

A logical reaction, of course, is: Can you measure whether good medical care *is* provided and what it costs?

You can. In terms of a broad "total" health-care problem, involving both *hospital care services* and *medical care in terms of physician-services*, it can be measured by a yardstick with a scale on each side. One side is Blue Cross, measuring *hospital care services and the costs.*

The other side—the side we are concerned with in measuring *medical care, in measuring doctor-services*—is Blue Shield.

Blue Shield is the fiscal agent directly for three out of four doctors in the state. In addition, Blue Shield pays the same scale of fees to the remaining doctors who are not "participating doctors" with signed

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legal agreements. Blue Shield provides coverage of vital doctor-services for some 40 per cent of Michigan's aged population. Of the 641,000 Michiganians who are 65 and over, approximately 250,000 are Blue Shield members.

So let's look at exactly how and at what cost Blue Shield gives them protection against the cost of vital *medical services* they need.

These 250,000 Michigan senior citizens in Blue Shield fall into four categories of Blue Shield: those retirees still in group plans; those who have changed from group plans to group conversion plans, either before or at the time of retirement; those with non-group keeping Blue Shield beyond age 65; and those in senior citizen non-group, the persons who joined Blue Shield after age 65.

They prepay their protection for doctor-services through Blue Shield at monthly rates ranging from $2.35 to $3.24 for single persons and for couples at monthly rates ranging from $5.77 to $6.48.

More specifically, single retirees in group plans pay $2.35 a month or $28.20 a year; those in group conversion or who enrolled in non-group plans before age 65 have a monthly rate of $2.59 or $31.08 a year; and the senior citizen non-group subscriber pays $3.24 a month or $38.88 a year.

What do they get for their money? Now even if these people do not get sick, they have a wonderful sense of security against unexpected surgical and medical bills—at a cost that amounts annually to about two packs of cigarets a week.

And what if they do get sick? One day's random sampling of Doctor's Service Reports taken in September, 1962, tells the story:

A total of 835 of the aged had bills, averaging $40, submitted that one day by their doctors. Attached to each bill for that day was the nine-month record of payment for each patient.

Over the nine-month period, Blue Shield paid out $173,104 for this one-day group of 835 senior citizens. This averages $207 per person for three-quarters of the year. *And these people paid INTO Blue Shield an average nine-month total of only $24.54.*

Many of the bills over the nine-month period would be staggering in any age group or for most pocketbooks. For example:

Blue Shield paid six doctors a total of $1,269 for an elderly male patient for extensive surgery in the lower abdomen, for intestinal lesions and therapeutic X-rays.

Blue Shield paid seven doctors a total of $1,185 for a heart-disease patient, who also had extensive surgery in the lower abdomen, with considerable pathology and X-ray.

Blue Shield paid six doctors a total of $1,167 for a person suffering from a urinary-tract disease, a broken ankle and a broken leg, with considerable X-ray charges.

Blue Shield paid seven doctors a total of $1,147 for a diabetic who was treated for a circulatory disease, stomach disease, a malignancy and underwent surgery to remove part of the intestinal tract.

Blue Shield paid eight doctors a total of $1,096 for an elderly woman suffering from cancer in the lower abdominal area.

Blue Shield paid 13 doctors a total of $1,038 for a senior citizen who had his large intestine removed and received treatment for heart disease, a deterioration of the oral cavity, the nervous system, along with several injections for bursitis.

And so it goes.

This is not the whole story, of course.

We can only cite cases of elderly people obtaining doctor-services which are a matter of record through Blue Shield.

The physicians of Michigan, like their brethren throughout the nation, treat thousands of others in this age bracket, some of whom have the means to pay for the medical services they get and some of whom do not. The physician knows his patients; the patient knows his physician. The patient is the first consideration, not the fee.

If a person needs medical attention, he gets it, finances notwithstanding.

SUMNER G. WHITTIER
Executive Director, Michigan Medical Service

Another Problem

In Michigan, the Kerr-Mills Bill was passed by our Legislature while President Eisenhower was in office. The Legislature provided that the care given to people over 65 (when need is demonstrated) be equivalent to Blue Cross and Blue Shield M-75 policy. Unfortunately, the Legislature failed to provide that the dispersing officers in government make the payments on the same basis as requirements for services. Many areas in the state are completely satisfied, others are not but could be made so. The main trouble is, as was expressed months ago, that this does not correspond to the political philosophy of the Washington administration and therefore a tip may have gone out to make the Kerr-Mills Bill administration difficult—or impossible. It is hoped the new State administration and the new Legislature will see the light and make a few minor changes in this bill. We have full confidence in Governor Romney. We believe from his announcements and addresses that he appreciates the people's difficulties and is willing to work for them. We hope his influence will help smooth out some of

the rough places. We have tried for so many years. Much improvement could be done and to a very good advantage to the people of the State of Michigan who are dependent upon these two public service trusts, Blue Cross and Blue Shield.

AMPAC

The recent AMA House of Delegates meeting in Los Angeles provided the opportunity before the session started to hold a special banquet to explain AMPAC (American Medical Political Action Committee). Reports were made of the tremendous work which had been done during the political campaign just passed.

The experience in Michigan is an indication of medicine at work. For the first time in 14 years, the State has been able to select an independent thinker, an ambitious and cultured man, a dedicated worker, and elected him as Governor. Past are fourteen years of submission to dominating forces in the higher government: labor bosses. All the speakers at this dinner stressed the fact that every doctor of medicine owes it to himself to contribute and to cooperate with AMPAC, which is not tied up to any political party. It supports the individual candidate when he indicates a sympathy with the point of view of the medical profession and a willingness to work with physicians in maintaining an independent and unhampered profession.

We hope most of our medical men in Michigan in this past year have turned in and helped this program. We hope that as soon as the new year starts we will do the same thing over again, because the problem will start all over again. As the new year starts a good tip would be for our members to join up with AMPAC and get interested and active.

Combined Opportunity and Duty

Another problem was brought to the attention of the membership in the House of Delegates itself, namely the loyalty of our medical graduates to their alma mater, and their willingness to help support and stimulate funds which the deans of the medical schools can use for legitimate and lawful purposes to help in retaining a valuable instructor or research worker.

Most of our doctors, at one time or another and many of them year after year, have contributed to their alma mater. President Eisenhower, when President of Columbia University, started a program on this order. He went to industry heads as well as to the medical leaders and members, and stimulated gifts which could be used for these purposes.

For many years, the AMA has urged such donations. Some states have made a fixed assessment a rule for each member. During the early session of the House of Delegates, a number of states made announcements of donations from a few thousands to $180,000 which had been collected in these states, the various amounts being turned over to the AMEF holding committee to be passed on to the deans of medical schools. This is a very worthy project and hopefully will be more extensively followed by more medical societies and graduates.

AMA—Fallacies and Facts

For more than a decade, a number of fallacies about the American Medical Association have appeared in the press, in speeches, or have been aired on radio and television. Most of these false statements have been written or spoken because of misunderstanding, misinformation, or lack of knowledge about the AMA.

Here is one of the most persistent fallacies about the AMA—and the facts:

Fallacy—The AMA is always "against" everything and never "for" anything.

Fact—The AMA has compiled a long, distinguished and enduring history of achievement in advancing the science and art of medicine. All of these accomplishments are a part of the printed record. No one, who has perused the record, would hint that such achievements could be accomplished by a regressive attitude.

In fact, the record shows AMA often suggested public health legislation 10 to 20 years before it became law. The AMA through the years has been against a lot of things—anything which in the collective judgment of the physicians who are the AMA would retard the advancement of medicine, would damage the quality of medical care in America or would hinder or destroy the free practice of medicine. Nevertheless, the AMA has been for much more than it has been against. Medical progress proves it and so does the congressional record. The Kerr-Mills Medical Aid for the Aged Law passed by Congress last year is one of the many measures supported by the AMA. In the 85th Congress, 700 bills affecting medicine directly or indirectly were introduced. The AMA testified on 28 measures, supporting 19 and opposing 6. Testimony on the others was purely informational. More than 700 such bills were introduced in the 86th Congress. The AMA submitted 43 statements on 25 bills. Only 6 statements on 4 bills were in opposition, 11 were informational and 26 were in support of legislation. A negative record? Hardly.

HEW Double-Talk

Health, Education and Welfare Secretary Anthony J. Celebrezze recently expressed the belief that state and local governments have the primary responsibility for welfare programs and other public services.

He told a National Press Club luncheon:

"The federal government's responsibility should be limited to those matters which are of primary national interest and cannot be effectively carried on through individual or local community efforts."

He also said that his basic welfare program policy would be to "help people help themselves."

But Celebrezze does not follow this philosophy of government to the point of weakening his support of the Kennedy Administration's social security hospitalization legislation. The Administration has said that it will push again for passage of such legislation in the new Congress convening January 9. But Celebrezze conceded it would be difficult to secure House approval.

The Administration gave no indication in pre-session talk whether the big push for the legislation would be made in this year or in 1964.

The House of Delegates of the American Medical Association, at its recent 16th Clinical Meeting in Los Angeles, reaffirmed its opposition to the Social Security approach in providing health care for the aged. The AMA also reaffirmed its support of the Kerr-Mills program.

George M. Fister, M.D., AMA president, said the AMA "will not compromise on the fundamental principles" in the controversy. Noting that the medical profession again faces a hard fight on the issue in Congress, Dr. Fister expressed confidence that "we can again win."

Dissension in Camp

Gov. John Swainson has been seeking votes on the ground that he is for President Kennedy's medicare program, but he carefully avoids spelling out that program. One campaign speaker this week, however, has laid the facts on the line.

He told an audience of chemical plant workers that under the Kennedy plan they would have to pay the first $90 of the hospital bill and that a complete medicare plan would cost not ¼ of 1 per cent but 1½ per cent in added Social Security taxes. Further, he reminded his listeners that by 1968 the Social Security tax will amount to almost 5 per cent each on employe and employer. He emphasized also that the President's plan would not pay doctor bills or pay for medicines used outside a hospital.

Although Republicans have made these points repeatedly in the present campaign it was not a Republican speaking in this instance. It was a Democratic representative in Congress, John Lesinski, from the Detroit area. Lesinski has been in Congress 12 years. He always has been friendly to labor and in the last session of Congress authored or coauthored bills to raise the minimum wage and government employes' salaries. He is for a great many things that John Swainson is for, but medicare isn't one of them. And the obvious reason is that medicare would be no bargain for the persons it purportedly would help most.

The best answer to providing medical care for the really needy lies in the Kerr-Mills act. It may not be perfect in its present form, but it does cover doctor as well as hospital bills and even now is going a long way toward providing medical care for those who can least afford it—those persons over 65 who no longer have steady incomes, or who are living on modest means. Moreover, it is working in Michigan. More than $11,000,000 was paid out in Kerr-Mills funds in this state in the first year's operations. Kent County is getting a half-million dollars a year from this source to help its ailing aged.

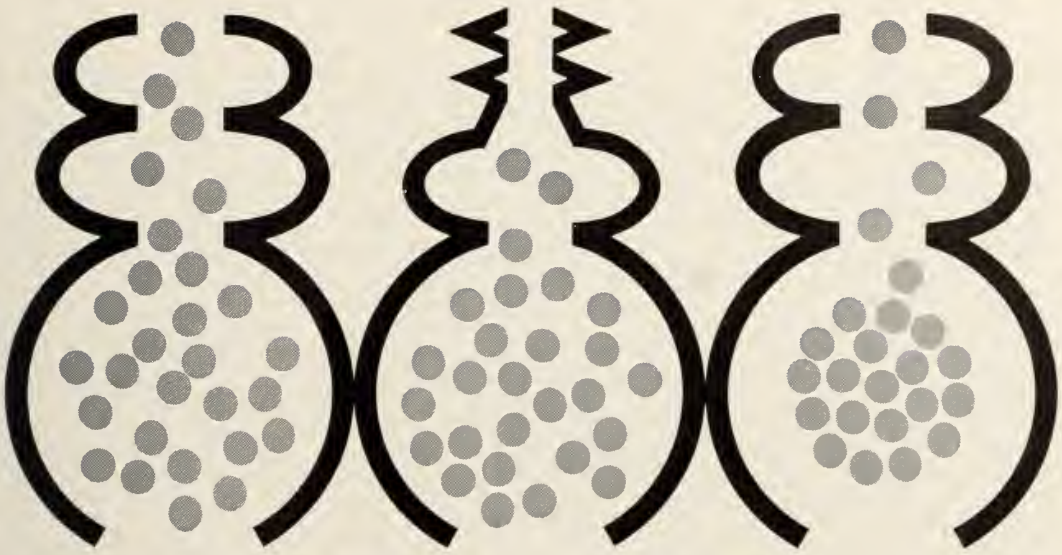
Gov. Swainson rarely alludes to the Kerr-Mills act, and if he does it is only to disparage it. He prefers the rejected King-Anderson bill, which would have aided only those covered by Social Security. We don't know why. Nor apparently, does his own fellow Democrat, Rep. Lesinski.—*Grand Rapids Press*, November 2, 1962.

Man in Numbers

Man, considered numerically, is an astounding creature, according to Dr. Frederic R. Stearns of Topeka, Kan. Thus: "The human heart beats on the average 70 times a minute or 2,575,440,000 times in the life span of 70 years . . . The blood vessels have a combined length of about 70,000 miles; the capillaries have together a surface area of an acre. The heart generates sufficient energy within two hours to lift a weight of 65 tons one foot in the air."

The genetic heredity of the present 2,750,000,000 population rests on a total of 5,500,000,000 germ cells: "this number of cells could be easily contained in about 2½-quart milk bottles. The sperm cells alone would occupy the space of less than an aspirin tablet, which means that all male hereditary material of all people now living and their progeny could be contained within the space of a little more than half of an aspirin tablet."

—*Clinical Medicine*



lowers motility | relieves cramping | stops diarrhea

LOMOTIL® Antidiarrheal tablets and liquid

(brand of diphenoxylate hydrochloride with atropine sulfate)

Traditionally the most effective means of slowing excess intestinal motility in diarrhea and so of relieving the disorder have been the opium derivatives. Now Lomotil makes available an antidiarrheal agent[1] of greater therapeutic efficiency than morphine.

By controlling hypermotility, the basic mechanical dysfunction of diarrhea, Lomotil reduces the frequency and fluidity of stools, diminishes cramping and controls diarrhea in many patients in whom other drugs have proved inadequate.

In a recent clinical report Cayer and Sohmer[2] state: "The alleviation of symptoms [with Lomotil] was usually prompt, occurring within 24 to 72 hours even in the long-standing chronic cases. . . . A surprisingly satisfactory response was obtained in 75 per cent of the patients with regional enteritis and in 63 per cent of those with ulcerative colitis, all of whom had failed to respond to other measures."

The high therapeutic efficiency of Lomotil, its safety, convenience and economy may be used to advantage in acute or chronic diarrhea.

Dosage: For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily. Maintenance dosage may be as low as two tablets daily.

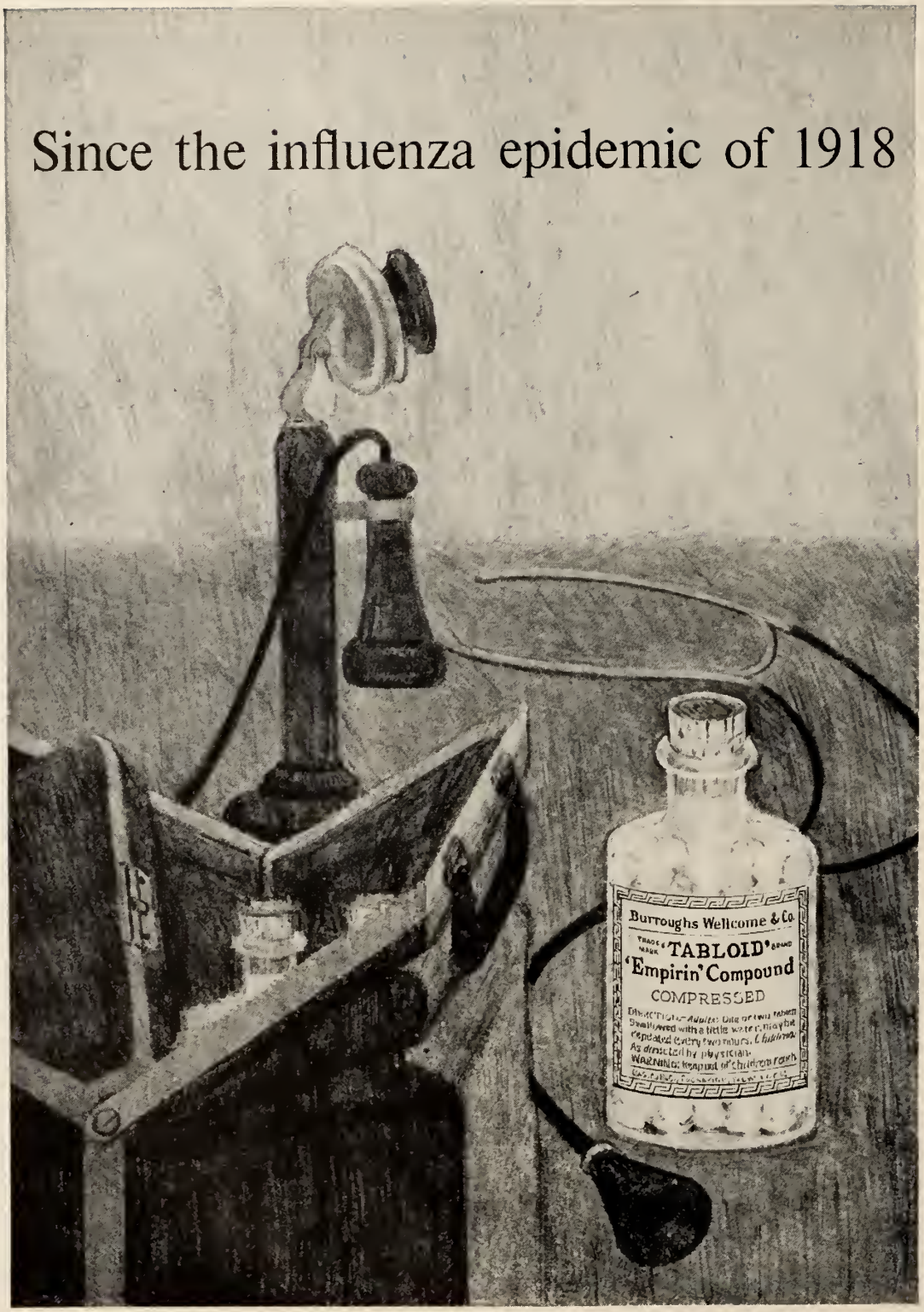
Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. Recommended dosage schedules should not be exceeded.

Note: Lomotil is an exempt preparation under Federal narcotic statutes.

Detailed information and directions for use in children and adults are available in Physicians' Product Brochure No. 81. G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

1. Janssen, P. A. J., and Jageneau, A. H.: A New Series of Potent Analgesics: Dextro 2:2-Diphenyl-3-Methyl-4-Morpholino-Butyrylpyrrolidine and Related Amides. 1. Chemical Structure and Pharmacological Activity, J. Pharm. Pharmacol. 9:381-400 (June) 1957.
2. Cayer, D., and Sohmer, M. F.: Long-Term Clinical Studies with a New Constipating Drug, Diphenoxylate Hydrochloride, N. Carolina Med. J. 22:600-604 (Dec.) 1961.

G. D. SEARLE & CO. *Research in the Service of Medicine*



Say you saw it in the Journal of the Michigan State Medical Society

....the first choice of many physicians to relieve aches, pains, fever, and general malaise of colds and flu.

Symptomatic and supportive treatment of patients with upper respiratory infections still consists largely of rest, analgesics, fluids and nasal decongestants. During the fateful influenza epidemic of 1918, 'Empirin' Compound was widely used and became well known as a well tolerated and reliable analgesic combination. It was one of the few available analgesic products effective in simultaneously reducing fever and relieving the general malaise which often accompany the flu.

Later, 'Empirin' Compound with Codeine took its place with the widely used 'Empirin' Compound, as a product useful when increased analgesia or antitussive action was desired. Today, 'Empirin' Compound with Codeine is one of the most widely prescribed drugs in medicine, providing physicians with a dependable analgesic, especially useful in relieving the symptoms of colds and flu. We believe you will also find 'Empirin' Compound with Codeine Phosphate gr. ¼ (16 mg.) or gr. ½ (32 mg.) particularly useful in treating the troublesome cough that is often part of the influenza symptom complex.

'EMPIRIN' COMPOUND with CODEINE PHOSPHATE *



gr. ⅛ gr. ¼ gr. ½ gr. 1



* Available on oral prescription where State law permits. Subject to Federal Narcotic Regulations.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



The good life—just what the doctor ordered

Sea and sun are both in his doctor's orders — so is that grapefruit he's eating with such gusto. Citrus fruit is a wonderful way for this patient or any patient to get his daily quota of vitamin C . . . to enjoy something good to eat, tasty and satisfying but not rich.

Not all patients are so lucky as to have retired to Florida, where they can just reach out to pick citrus fruit off their own orange and grapefruit trees. But any patient anywhere can get the same benefits of the natural vitamin C in Florida oranges, grapefruit, and tangerines . . . thanks to modern methods of processing fresh fruit. Whether it is frozen, canned, or in cartons, 98% of the vitamin C content of the fruit is preserved.

Grapefruit and other citrus fruits filled with vitamin C are valuable in the nutrition of every age group. Among the teen-agers, vitamin C is one of the two nutrients most often low in the diet. Infants, too, need generous amounts of vitamin C; and they will take it readily when it comes to them in the form of delicious orange juice.

When your patient chooses *Florida* citrus, he can be sure of getting fruit filled with natural goodness and of just the right sweetness. Florida citrus is unexcelled because a State commission watches over the entire Florida citrus crop to see that it meets the world's highest standards for fresh, frozen, canned, or cartoned citrus fruits or juices.

© Florida Citrus Commission, Lakeland, Florida

New Pharmacy Act Explained for Doctors

By Robert C. Johnson, *Executive Director, Michigan State Pharmaceutical Association*

Several portions of the new Michigan Pharmacy Act (P.A. 151, 1962) will be of special interest to Michigan doctors of medicine. The Act shall take effect on March 28, 1963.

Following are the sections which apply to doctors of medicine.

Sec. 1. Defines *Prescription* as an order for drugs or devices written, signed or transmitted by word of mouth, telephone, telegraph or other means of communication by a physician, dentist or veterinarian, to be filled, compounded or dispensed, but if the order is transmitted in other than written form, it shall be recorded in writing and immediately dated by the pharmacist, and such record shall constitute the original prescription; and

Substitute is to dispense without the prescriber's authorization a different drug or brand of drug in place of the drug or brand of drug ordered or prescribed. (Under Sec. 17 it is a misdemeanor to substitute.)

Sec. 15. Permits the Pharmacy Board to revoke or suspend a pharmacy license for the following:

—Failed to comply with the rules of professional conduct.

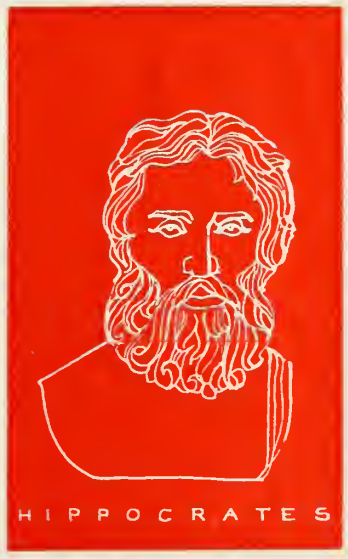
—Promoted to the public in any manner a drug which may only be dispensed pursuant to a prescription.

—Employed the mail to sell, distribute, or deliver a drug which requires a prescription when the prescription for such an article has been received by mail.

Sec. 17. It is a misdemeanor for:

(g) Any physician, dentist or veterinarian to permit the compounding or dispensing of drugs in the course of his professional practice by any person not permitted by this Act to compound or dispense drugs, except under his *immediate supervision.*

Sec. 19. A drug intended for use by man and which is a habit forming drug or because of its toxicity or other potentiality for harmful effect, or the method of its use, or the collateral measures necessary to its use, is not safe for use except under the supervision of a practitioner licensed by law to administer such drug shall be dispensed only upon a written prescription of a practitioner licensed by law to administer such drug, or upon an oral prescription of such practitioner which is reduced to writing, immediately dated, and filed by the pharmacist, or by refilling any written or oral prescription if the refilling is authorized by the prescriber either in the original prescription or by oral order which is reduced promptly to writing, immediately dated, and filed by the pharmacist. The Board by regulation may remove drugs from the requirements of this section when such requirements are not necessary for the protection of the public health. In addition to the provisions of this section, all narcotic laws



and regulations thereunder shall be complied with.

Sec. 28. Except as to the *quality* of drugs dispensed, this Act shall not apply to the practice of a physician or dentist or veterinarian, or prevent *him* with supplying his patients with such drugs as he may deem proper and as permitted by law *if*:

(1) The drugs are dispensed in a container the label of which bears the name and address of the patient, directions for use, and date of delivery; and

(2) He is not a proprietor of a pharmacy or an employee of such a proprietor.

Four Elected to Michigan "Health Hall of Fame"

Four Michigan citizens were elected to the "Michigan Health Council Health Hall of Fame" at the Council's recent state conference at Ann Arbor. The four, two of whom are deceased, were recognized for outstanding contributions to the health of Michigan's citizens. They are Harry B. Zemmer, M.D., Lapeer, S. S. Kresge, Detroit; Henry F. Vaughan, Dr. P.H. and Frederick G. Novy, M.D., Ann Arbor.

Doctor Zemmer who died November 11, 1962, was President-Emeritus of the Michigan Health Council, formerly on the Michigan State Mental Health Commission and a member of the Michigan Commission on Aging.

Mr. Kresge is the founder of the S. S. Kresge Company and the Kresge Foundation, which has granted many millions to the University of Michigan Medical School and Wayne State University College of Medicine for the construction of medical buildings, including the Kresge Eye Research Institute and Kresge Hearing Institute.

Doctor Vaughan is Dean Emeritus of the School of Public Health at The University of Michigan, president of the National Sanitation Foundation and a trustee of the W. K Kellogg Foundation.

Doctor Novy, who died on August 8, 1957, at the age of 92, retired as Dean of The University of Michigan Medical School in 1953. Three sons, Frank O., Robert L. and Frederick G., followed their father's footsteps and became doctors of medicine.

In addition to the Health Hall of Fame awards, the Council also presented the A. S. Brunk Award to the Roseville Health Council and the Earl Ingram Carr Award to the Taylor Community School Health Council for the most outstanding community and school health programs in Michigan during the past year.

Miss Mary Ellen Redmond, R.N., of Bay City, received the Michigan Health Council Annual Award for Outstanding Achievement in Public Health. She served as director of the Civic League Nursing Service in Bay County for more than 40 years.



SAGINAW MEDICAL ASSISTANT HONORED

Mrs. Lorine Luplow, Saginaw, received the "Michigan State Medical Assistant of the Year Award" from Fred C. Henderson, of the Detroit Medical-Dental Hospital Bureau, at the 1962 MSMAS Convention. Mrs. Luplow is a member of long standing of the Saginaw County Medical Assistants Society.

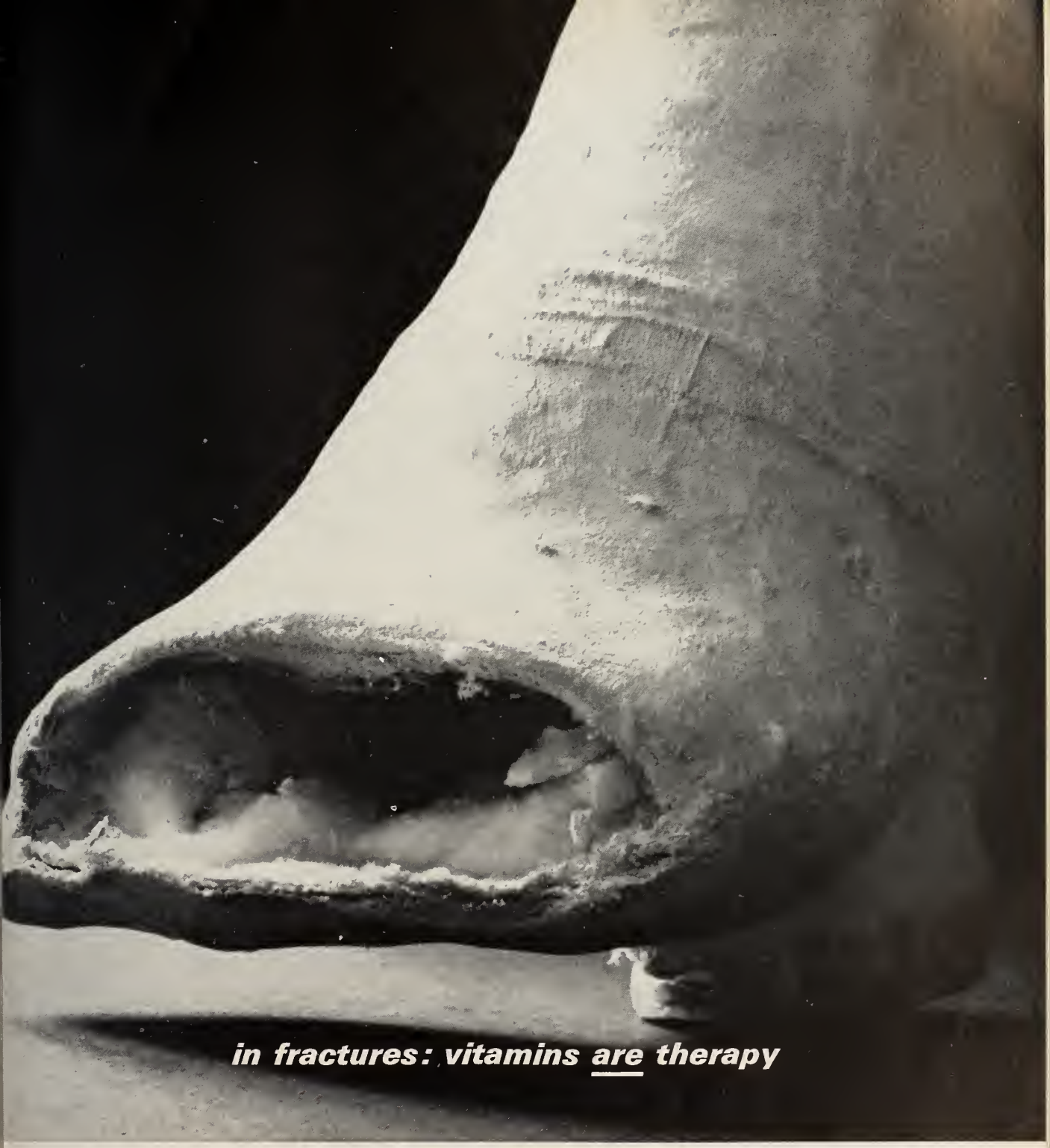
Communications Awards were presented to WJRT-TV, Channel 12, Flint, for outstanding television coverage during the Council's state conference in Flint in 1961, and to Radio Station WILS, Lansing, for their cooperation in making special daily public service announcements on the availability of baby emergencies posters and other Health Council publications.

Michigan Orthopaedic Society Elects Officers

Herbert W. Harris, M.D., Lansing, is the new president of the Michigan Orthopaedic Society. Other officers elected at the annual meeting, held in Detroit, are Hira Branch, M.D., Flint, president-elect; and Richard W. Pomeroy, M.D., Lansing, secretary-treasurer.

Special MMS Phone for Doctors

To assist doctors with their phone calls to Michigan Medical Service, Blue Shield has installed a special telephone number for doctors: 965-3500. Sidney Adler, M.D., MMS President, invites doctors to use this new phone number and "tell the special switchboard operator that you are a physician and she'll connect you at once with the special section on Professional Relations."



Few factors are more fundamental to tissue and bone healing than nutrition. Therapeutic allowances of B and C vitamins are important for rapid replenishment of vitamin reserves which may be depleted by the stress of fractures. Metabolic support with STRESSCAPS is a useful adjunct to an uneventful recovery. Supplied in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

STRESSCAPS®

Stress Formula Vitamins Lederle

Invite MSMS Members to Attend MAP Congress

Several MSMS members will carry responsible assignments at the 1963 MAP Congress of the Professions, February 8-9, in Lansing.

Clarence I. Owen, M.D., Detroit, MSMS President, will serve as an honorary chairman.

G. B. Saltonstall, M.D., Charlevoix, Past President and member of MAP Executive Committee, will preside at an interesting session Saturday morning February 9 on "How to Build Better Cities."

Homer H. Stryker, M.D., Kalamazoo, will give his clever speech about "How to Go Into Business" at the Friday Luncheon, February 8.

Other doctors will serve on the four standing committees which will hold "hearings" Friday morning.

Every component medical society has been requested by MAP to appoint official delegates to this Fourth Annual Congress.

One of the biggest stars on the MAP program will be Edward R. Annis, M.D., Miami, President-Elect of the AMA.

All members of MSMS, whether MAP members or not, are invited to attend the Congress. A complete program may be obtained by writing MSMS, Box 152, East Lansing.

Health Council Reports 16 M.D. Placements

Recent placements by the M.D. Placement Service have included the following: Donald R. Kay, M.D. (Addison); G. David Hoag, M.D. (Hastings); Herminio A. Armovit, M.D. (Onsted); Louis E. Harrington, M.D. (Lansing); Benjamin F. Koepke, M.D. (Marquette Branch Prison); John Joseph Kennedy, M.D. (Owosso); Walter S. Daily, M.D. (Niles); Edward G. Krug, M.D. (Buchanan); Dennis R. Burke, M.D. (Ann Arbor); Chan Namtze, M.D. (Cassopolis); Martin F. Jones, M.D. (Lansing); Arthur M. Freedman, M.D. (Detroit); Clark B. Smith, Jr., M.D. (Hillsdale); William P. Steffee, M.D. (North Muskegon); Louis E. Sanford, M.D. (Belding); Thomas K. Busard, M.D. (Muskegon).

U-M Hospital Sets Patient-Day Record

The University of Michigan Medical Center set new highs this past year in providing patients with radiology treatments, drug prescription and lab tests.

Hospital Director A. C. Kerlikowske, M.D., reports more than 21,000 patients spend 300,284 "patient days" in the hospital, an increase of 5,396 over the previous year.

At the same time examinations and minor treatments in the hospital's outpatient services climbed 4,569 for an all-time high of 233,442, he reported.

The hospital's annual report shows record highs of 20,723 radiology treatments, 215,848 laboratory tests and 262,750 drug prescriptions.

Hospital financial operations were based on a one-year budget of $15,863,280. University Hospital, except for its psychiatric unit, is a self-supporting branch of the U-M and derives all income from fees charged to patients. Seventy-two per cent of the budget went into salaries and wages for nearly 3,000 hospital employees.

The hospital's economic picture last year was marred by the loss of over $300,000 through services provided to children under the State's crippled afflicted children's programs. Actual costs to the hospital for the care of these children range up to $100 but, by law, the State pays a maximum of $25.

"Slimmersbord" Offered

Participants at the recent meeting of the Michigan Dietetic Association at Battle Creek were treated to a "slimmersbord."

The "slimmersbord," as you may have guessed is a smorgasbord for reducers. The special menu contained no meat dishes, but a wide choice of low calorie hot dishes, salads, fruits and desserts.

Elected to Lead G. P.'s

Lyle Korum, M.D., Grosse Pointe, was chosen president-elect of the Michigan Academy of General Practice at its convention in Detroit.

Installed as president for the current year was Leighton O. Shantz, M.D., Flint.

U-M Gives Honorary Degree to Doctor Kennedy

Charles S. Kennedy, M.D., Detroit, received a honorary Doctor of Laws degree at the University of Michigan Triennial Medical Center Alumni Conference. More than 400 U-M medical alumni and wives attended the conference.

In the citation with the honorary degree, the University said, "Doctor Kennedy has distinguished himself as a master surgeon, a respected teacher of surgery, and an effective administrator."

MSMS presented to Doctor Kennedy at the 1962 House of Delegates a "Certificate of Commendation."

A graduate of the U-M, Doctor Kennedy served the University as a Regent for 16 years.



Relieves Anxiety and Anxious Depression

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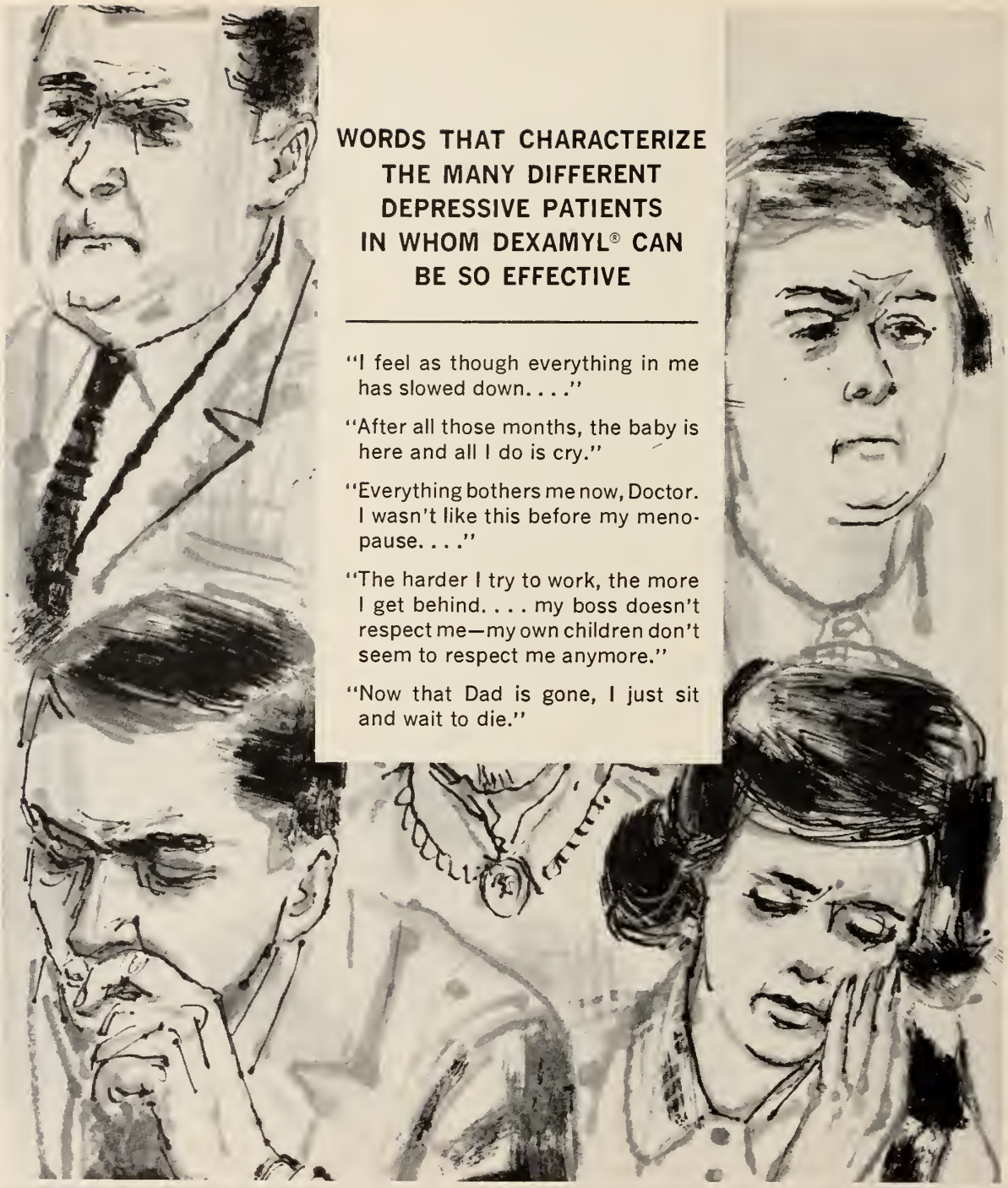
Of practically all drugs now used clinically as expectorants, glyceryl guaiacolate exerts the most intense and prolonged action.

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Robitussin A-C also contains pheniramine maleate to control associated allergic manifestations and codeine phosphate to suppress persistent, unproductive coughs.

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"Everything bothers me now, Doctor. I wasn't like this before my menopause. . . ."

"The harder I try to work, the more I get behind. . . . my boss doesn't respect me—my own children don't seem to respect me anymore."

"Now that Dad is gone, I just sit and wait to die."

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FORMULA: Each 'Spansule' capsule No. 1 contains 10 mg. of Dexedrine® (brand of dextro amphetamine sulfate), and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Spansule' capsule No. 2 contains 15 mg. of 'Dexedrine' (brand of dextro amphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming]. The active ingredients of the 'Spansule' capsule are so prepared that a therapeutic dose is released promptly and the remaining medication, released gradually and without interruption, sustains the effect for 10 to 12 hours.

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USUAL DOSAGE: One 'Dexamyl' *Spansule* capsule taken in the morning for 10- to 12-hour effect.

SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

CAUTIONS: Use with caution in patients hypersensitive to sympathomimetic compounds or barbiturates and in coronary or cardiovascular disease or severe hypertension.

SUPPLIED: 'Spansule' capsules No. 1 (1 dot on capsule) and No. 2 (2 dots on capsule), in bottles of 30.

Prescribing information October 1962.

Smith Kline & French Laboratories

HEART BEATS

(This material is provided by the Michigan Heart Association)

February Meeting Commemorates Heart Month

Commemorating Heart Month, the Michigan Heart Association will present a two-day program in Detroit, Friday and Saturday, February 8 and 9, 1963.

PROGRAM

Friday, February 8

HEART DISEASE AND THE LAW—Panel Discussion

Grand Ballroom, Statler Hilton Hotel, Detroit

1:30 P.M.-4:30 P.M.

Keynote Speaker: Paul Dudley White, M.D.

Chairman: E. A. Irvin, M.D., Medical Director, Ford Motor Company.

Panel Members: Prof. John V. Thornton, New York; Herman Hellerstein, M.D., Cleveland; and Robert B. Lacey, attorney, Detroit.

AN EVENING WITH DR. PAUL DUDLEY WHITE—

Panel Discussion for the General Public

Program co-sponsored by the *Detroit Free Press*

Ford Auditorium, Detroit

8:30 P.M.

Keynote Speaker: Paul Dudley White: "Work: For the Maintenance and Restoration of Health."

Moderator: Muir Clapper, M.D., President, Michigan Heart Association

Panel Members: Richard J. Bing, M.D., Warren B. Cooksey, M.D., F. D. Dodrill, M.D., Sibley W. Hoobler, M.D., Aaron M. Stern, M.D., all of Michigan, and William Dock, M.D., Brooklyn, N. Y.

Saturday, February 9

RESEARCH OF TODAY IS THE CLINICAL PRACTICE OF TOMORROW—MHA Scientific Sessions

Grand Ballroom, Statler Hilton Hotel, Detroit

9 A.M.-5 P.M.

Chairman: Richard J. Bing, Chairman, Department of Medicine, Wayne State University, College of Medicine, Detroit

Eleven 10-minute talks; three 30-minute discussions; a panel discussion

"An Experimental Approach to the Problems of Nervous Tension and Coronary Artery Disease"—A. Clifford Barger, M.D., Boston

"Intermediary Myocardial Lipid Metabolism in Dogs and Normal Human Subjects"—Thomas A. Bruce, M.D., et al, Wayne State University

"Mode of Action of Chlorothiazide Diuretics"—James Conway, M.D., University of Michigan

"Intracardiac Phonocardiographic Ventricular Defect Localization"—Aaron M. Stern, M.D., et al, University of Michigan

"Thyrotoxic Heart Disease"—Vernon E. Wendt, M.D., et al, Wayne State University

"Determination of Myocardial Blood Flow Using Rubidium-84 and a Coincidence Counting Technique"—Arvin Bennish, M.D., et al, Wayne State University

"Coronary Artery Disease"—William Dock, M.D., Brooklyn, N. Y.

"Objective Comparisons of Stethoscopes"—Paul Y. Ertel, M.D., et al, University of Michigan

"Mechanisms of Vascular Alterations in Septic Shock"—Elmer E. Kobold, M.D., et al, Wayne State University

"Heart Surgery and the Changing Responsibility of the Physician"—Dwight E. Harken, M.D., Boston

"Diagnosis and Successful Surgical Removal of Left Atrial Myxoma"—Rodman E. Taber, M.D., Henry Ford Hospital

"Surgical Problems Encountered with the Implantable Pacemaker (?)"—Joe D. Morris, M.D., et al, University of Michigan

"Resection of Left Ventricular Aneurysms"—Conrad R. Lam, M.D., et al, Ford Hospital

PANEL: "Present, Past and Future of Heart Surgery"

Moderator: Dwight E. Harken, M.D.

Panel Members: James B. Blodgett, M.D., F. D. Dodrill, M.D., F. D. Johnston, M.D., Conrad R. Lam, M.D, Richard A. Rasmussen, M.D., and Robert Ziegler, M.D.

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USUAL DOSAGE: 2 tablets, 4 times a day. Maintenance dosage is frequently lower.

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- **N**eo-Synephrine® hydrochloride 0.5 per cent—opens engorged nasal passages, shrinks sinus ostia and provides proper breathing and drainage space.
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- **Z**ephiran® chloride 1:5000 (antibacterial wetting agent and preservative)—promotes spread and penetration to less accessible nasal areas.

NTz is well tolerated by the delicate respiratory tissues. In several hundred patients treated with NTz, there were "...no deleterious effects from...frequent and prolonged use."*

NTz Nasal Spray is also useful in vasomotor (allergic) rhinitis and sinusitis. It is best used twice within five minutes. Supplied in leakproof, pocket-size, squeeze bottles of 20 ml. and in bottles of 30 ml. with dropper.

*Levin, S. J.: **Pediat. Clin. North America** 1:975, Nov., 1954.

NTz, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran chloride (brand of benzalkonium chloride, refined), trademarks reg. U.S. Pat. Off.

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Say you saw it in the Journal of the Michigan State Medical Society

New Congress Hopes for Shorter Session

The 88th Congress of the United States convened on January 9—with all congressmen hoping it will not stay in session as long as the 87th Congress. No other Congress in the past decade continued as late in session in an election year—from January 3 to October 13, 1962.

During the 87th Congress, the American Medical Association testified or submitted written statements on twenty-one occasions. The AMA favored, in whole or in part, ten of the bills and opposed seven.

The American Medical Association maintains an active interest in federal legislation. Its records and resources, publication, materials and expert opinion impose an obligation on the Association to present medicine's comments, suggestions and viewpoints on measures which can affect the practice of medicine or the health of the public. Members of Congress, Congressional Committees and Administrative agencies often solicit the expert opinion of the AMA on matters pending or to be proposed. On occasion, one or more AMA "witnesses" appear before a Congressional Committee to relate the Association's position on a bill. At other times, formal statements are submitted to the Committees without personal appearances. On many other occasions, the AMA, by letter, volunteers an opinion or responds to a request for comment on a proposal made or about to be made to the Congress.

During 1961 and 1962, over 20,000 measures were introduced in both Houses of Congress. Sixteen hundred and forty bills were of sufficient interest to medicine to be studied by the Legislative Council of the American Medical Association.

Says Administration Uses Cheese Knife

"The compulsory Medicare plan of the Administration I regard as a clumsy, callous, inequitable attempt to solve, in a broad scale manner, a limited problem. It is a clumsy approach that these political surgeons have used to conduct this operation with the anesthesia of somewhat dubious propaganda and with the use of something like a cheese knife instead of a scalpel."

—Ladd Plumley, *President, Chamber of Commerce of U.S.*



MICHIGAN DEPARTMENT OF HEALTH
ALBERT E. HEUSTIS M.D., State Health Commissioner

X-Radiation Control in Physicians' Offices

In February 1958, regulations governing the use of all forms of ionizing radiation were printed in Supplement 13 to the Michigan Administrative Code. Thus the state health commissioner became legally responsible for implementing these regulations with the advice and counsel of a radiation advisory committee.

The basis for drawing up these regulations governing radiation was to protect the public health. The concern of the Department is to protect people from unnecessary or accidental exposure to any form of ionizing radiation. It should be made clear that nothing in the regulations can be interpreted as limiting the *intentional* exposure of patients to radiation for the purpose of diagnosis, therapy, or research which is being conducted by a licensed member of the health professions.

One section of the code requires that all sources of ionizing radiation be registered with the state health commissioner by the legal owners, users, or authorized representatives. Since the regulations went into effect, about 6,000 x-ray machines have been registered with the State Health Department. We estimate that this represents only about 75 per cent of all such machines.

Primary emphasis at the beginning of the program has been on the registration and checking of x-ray machines used by chiropractors and by dentists. The chiropractors were the first group to be checked out and almost all of their machines have now been registered with the health department. Because of the large number of dental x-ray machines, it was not possible to check them by personal visits. Instead, all dentists in the state were mailed a sealed package containing x-ray film. They were asked to expose the film to their x-ray equipment and return it unopened to the Department. After the film was developed and analyzed, if a machine was found to be emitting too much radiation or scattering it over too wide an area, the destist was provided with a lead disk and aluminum filters to control excessive radiation. At this time, almost all dental x-ray machines have been checked and now emphasis is being placed on x-ray machines in physicians' offices.

We are concerned with the operation of these machines only to the extent that they function as efficently as possible allowing minimum exposure to a minimum area with maximum benefit. To check these x-ray machines, State Health Department engineers are making personal calls on all physicians who have such equipment. At the present time, most of these calls are being made on physicians whose machines are registered with the State Health Department. However, we estimate that only about half of the doctors of medicine and osteopaths have yet registered their machines as required by the regulations. Undoubtedly, this results from the fact that many physicians still do not realize the necessity for registering their equipment with the State Health Department. However, now that the department is able to place primary emphasis on these machines it is fully expected that all physicians' x-ray equipment will be registered within the near future.

When an engineer calls on a physician to check his equipment, the first thing he determines is whether or not the machine meets radiation regulation requirements; such as diagnostic tube housing, collimation and filtration of the beam. Next, the room enclosure and biological protective shields for the operator are checked. If excess radiation is found or if there is an unnecessary amount of scatter radiation, the engineer will recommend modifications involving the installation of cones, diaphragms, or collimators. After these changes have been made the machine will be rechecked to assure that the modifications have achieved the desired result.

At present, about half of all x-ray machines have been checked out. The results even at this stage are significant. Over all, our engineers have been able to reduce primary radiation in the average machine by about two-thirds. In addition, body exposure area has been reduced by about one-third, thus resulting in the elimination of unnecessary exposure to vital organs such as the gonads, thyroid, and the eyes which had previously been irradiated when the body part being x-rayed was near such an organ.

A conservative estimate (assuming only two exposures per machine per day six days a week) indicates that the program has already accomplished a total reduction of unnecessary radiation to Michigan

(Continued on Page 112)

Digest of AMA Interim Meeting

By William A. Hyland, M.D., *Chairman*
Michigan Delegation to AMA

More than 400 papers, discussions and seminars attracted major interest at the AMA interim meeting in Los Angeles. This short summary of the AMA meeting will include highlights of the House of Delegates meetings and brief comments by some of the medical authorities.

Medical Speakers

The incidence of lung cancer appears almost certainly to reflect the combined effects of the exogenous environmental agents as modified by endogenous host factors, the former emphasizing polluted urban air, cigaret smoke and viral infections, according to Paul Kotin, M.D., chief of carcinogenesis studies branch of the National Cancer Institute.

The actual number of suicides in the United States is "considerably larger" than the 19,500 recorded, Louis I. Dublin, M.D., a member of the board of National Institute of Mental Health, said. He reported that more than half the total coming after persons reach age 45.

More than half of the 16 per cent of infertile married couples in the United States could have children under proper treatment, declared Marie Pichel Warner, M.D., director of the Fertility Clinic at Grand Central Hospital in New York. She said she had found successful pregnancies in 60 per cent of the infertile couples at the clinic who completed all tests and continued treatment.

T. Phillips Waalkes, M.D., head of the cancer chemotherapy program of the U. S. Public Health Service, said he was optimistic about discovering a drug to cure cancer but he pointed out that the problem was complicated by the many forms of the disease. He said cancer is not one disease but 100 to 150 of them. He said it was "highly unlikely" that one drug would ever be discovered which would be a "universal cure" for cancer.

A new drug treatment of muscular dystrophy, the advancing, muscle-wasting disease, with "impressively encouraging results" was reported by Robert M. Dowben, M.D., assistant professor of medicine at Northwestern University Medical School. He has developed the treatment which consists in the use of two kinds of "steroid" drugs. They are: 1. I-Methyl-Delta I-Androstenolone, and 2. Digitoxin.

A solvent effective in dissolving three types of kidney stones which constitute about 40 per cent of those occurring in this country was described by William P. Mulvaney, M.D., a Cincinnati urologist. He said the solution called "hemiacidrin," can in some cases prevent the recurrence of stone formation.



Lester Breslow, M.D., of the California Department of Public Health, predicted: "If present trends continue, more than one million U. S. children now of school age will die of lung cancer."

Hormone therapy to help regulate height has a much better potential in the 8-9 year old child than one who has reached puberty, M. James Whitelaw, M.D., reported. He said, under proper supervision, hormonal treatment of excessive height and short stature in the vast majority of children produced good results that have far reaching psychological effects.

Leg cramps or spasms of the calf muscles, a common and painful complaint in the later months of pregnancy, can be relieved in the majority of cases by drug therapy, Herschel S. Murphy, M.D., of Roselle, N. J., reported. He stated isoxuprine hydrochloride was found to be both safe and effective in treating a series of 100 expectant mothers.

Jeanne C. Bateman, M.D., and Harry N. Carlton, M.D., Washington, D. C., reported that the administration of Thio-Tepa according to the prescribed dosage schedule benefited patients with advanced recurrent mammary carcinoma as well as patients so-called "inoperable" carcinoma. It is suggested that present survival rates in mammary carcinoma can be improved by the early use of a chemotherapeutic drug such as Thio-Tepa.

Action of Delegates

The House of Delegates reaffirmed the present AMA policy regarding free choice of physician and opposition to any form of legislation in, or government control of, the practice of medicine was foremost on the program.

The House reaffirmed, without change, the Association's present policy of opposition to the King-Anderson type of legislation and support for the Kerr-Mills program. It also approved in principle the following suggested amendments to the Kerr-Mills Law:

1. Remove the requirement that both Old Age Assistance (OAA) and Medical Assistance for the Aged (MAA) programs be administered by the same agency;
2. Provide flexibility in the administration of the income limitations proposed under state law so that a person who experiences a major illness may qualify for benefits if the expense of that illness, in effect, reduces his money income below the maximum provided;
3. Include a provision in the law requiring state administering agencies to seek expert advice from physicians or medical societies through medical advisory committees; and
4. Provide for "free choice" of hospital and doctor under state programs.

The House also endorsed in principle four proposed amendments to the Internal Revenue Code, designed to assist in financing the medical and hospital expenses of the aged. These amendments would: liberalize tax deductions for medical expenses of dependents over age 65; remove the 1 per cent drug limitation and include drugs as medical expenses; permit taxpayers over age 65 to receive full tax benefit for medical expenses by use of the carry-forward and carry-back principle, and provide a tax credit for medical expenses paid by the over age 65 taxpayer, proportionate to the relation between his medical expense and taxable income.

One report was approved which concluded with the following declaration:

"It is our strong conviction that the legislative situation, the expanding health insurance and prepayment coverage, the improving economic status of the aged, and the many other factors cited in this report require that we face the 1963-1964 Congressional campaign without defeatism or complacency and with pride in the progress which has occurred. Finally, it is, above all, essential that our position not be undermined by the adoption of any policies that compromise our basic principles."

There were also several other discussions including seven resolutions on issuing a direct statement for all members of the A.M.A. to refuse by pledge to accept any fees from the government for medical services to those able to pay their own way.

Further—Graduate education in medicine, medical ethics, health services to the aged, a review of the sections and scientific program were discussed.

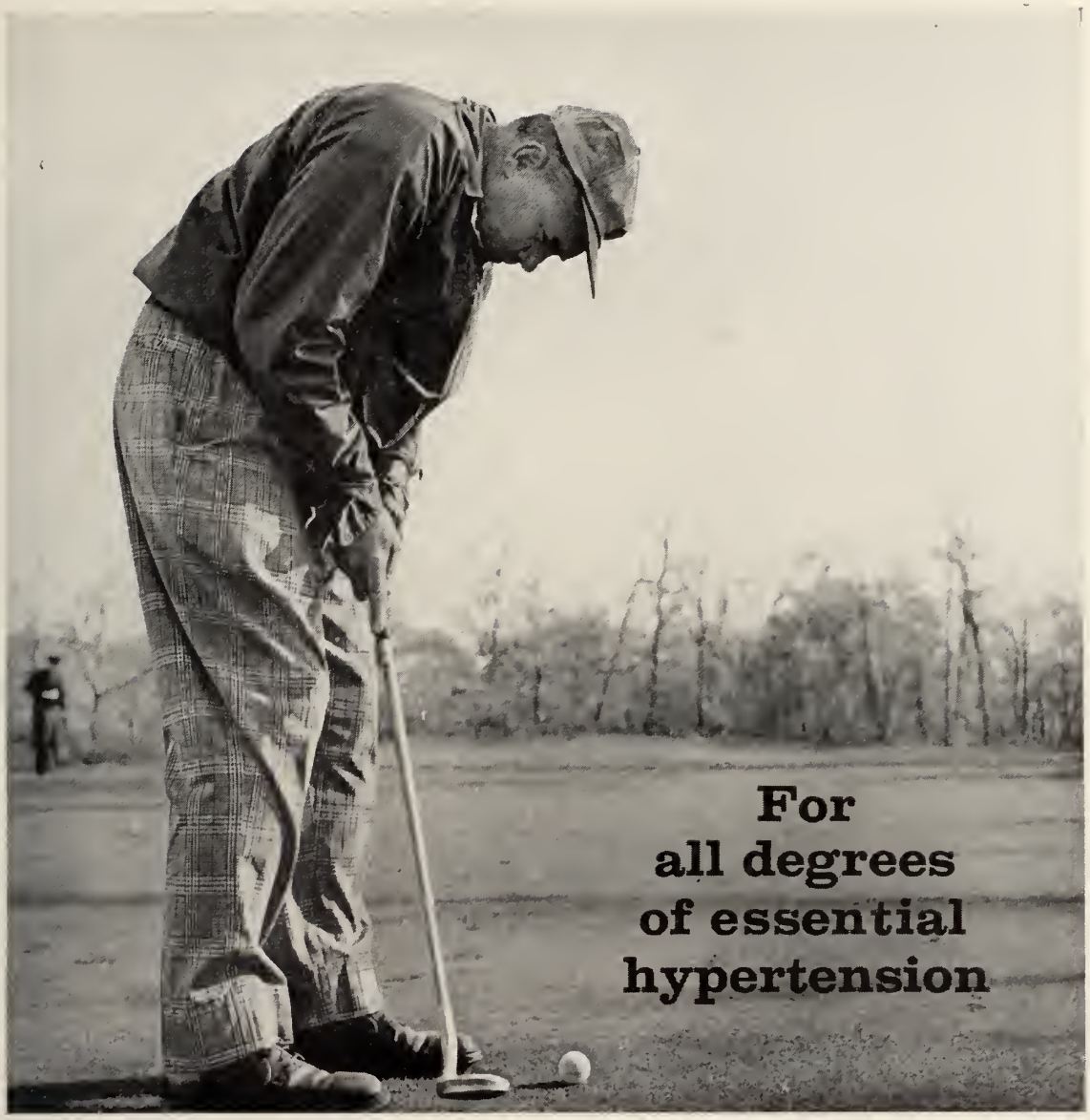
Over five thousand physicians were registered, with a total of around twelve thousand in attendance, including hospital personnel, technicians, nurses and exhibitors.

A report was made by the American Medical Association Education and Research Foundation that one out of every ten medical students in the U. S. is now benefiting from the new student loan program. Since its beginning nine months ago, the program has granted loans totaling more than nine million dollars to 3,042 medical students and 1,787 interns and residents, with applications being received at a rate of 150 per week.

HOPE to be Aided By National Women's Club

The over 100,000 Junior Clubwomen of the General Federation of Women's clubs have chosen Project HOPE as their target for 1962-64. Mrs. Dexter Otis Arnold, president of the Federation, believes Project

(Continued on Page 100)



"relief of symptoms is striking with Rautrax-N"†

Rautrax-N decreases blood pressure for almost all patients with mild, moderate or severe essential hypertension. Rautrax-N also offers a new sense of relaxation and well-being in hypertension complicated by anxiety and tension. And in essential hypertension with edema and/or congestive heart failure, Rautrax-N achieves diuresis of sodium and chloride with minimal effects on potassium and other electrolytes.

Rautrax-N combines Raudixin (antihypertensive-tranquilizer) with Naturetin c̄ K (antihypertensive-diuretic) for greater antihypertensive effect and greater effectiveness in relief of hypertensive symptoms than produced by either component alone. Rautrax-N is also flexible (may be prescribed in place of Raudixin or Naturetin c̄ K) and economical (only 1 or 2 tablets for maintenance in most patients).

Supply: Rautrax-N — capsule-shaped tablets providing 50 mg. Raudixin, 4 mg. Naturetin and 400 mg. potassium chloride. *Rautrax-N Modified* — capsule-shaped tablets providing 50 mg. Raudixin, 2 mg. Naturetin and 400 mg. potassium chloride.

†Hutchison J. C.: Current Therap. Res. 2:487 (Oct.) 1960.

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HOPE to be Aided by National Women's Clubs

(Continued from Page 98)

HOPE is one of the most humanitarian projects ever attempted by the U. S. "I regret," she said, "that there is only one ship. We need many more."

The General Federation of Women's Clubs is the first national women's organization which has voted to support HOPE.

AMA Meetings

Listed below are the dates and places of the 1963-64-65 AMA Annual Meetings and the Clinical Meetings:

1963 Annual Meeting, Atlantic City, June 16-20.
1963 Clinical Meeting, Portland, Oregon, December 1-4.
1964 Annual Meeting, San Francisco, June 21-25.
1964 Clinical Meeting, Miami Beach, November 29-December 2.
1965 Annual Meeting, New York City, June 20-24.

Sweden Needs Facilities

Sweden, considered one of Europe's most advanced welfare states, is desperately short of hospital and nursing home beds for the aged sick. Trained personnel is also in short supply. Swedish planners hope eventually to accommodate roughly *10 per cent* of the over-seventy population in institutions; working toward this goal, the government has built 720 nursing homes in the past 15 years.

Copenhagen Has Night Crew

Sixty physicians in Copenhagen make about 100,000 house calls at night and on Sundays. They belong to the Danish medical organization known as Laegevagt or "doctor watch." For the most part, the doctors are residents and eager to earn the extra $3,000 they receive for working five hours a night seven nights a month, including tours of duty on Sundays and holidays.

British Drug Industry Acts

British pharmaceutical manufacturers, like their American counterparts, have set up a special body to strengthen safeguards against toxic side effects of new drugs.

In a parallel move, Britain's chief medical research body, the Medical Research Council, announced the creation of a special committee to advise the Ministry of Health on drug testing.

Hussey to Direct AMA Scientific Work

Hugh H. Hussey, M.D., dean of Georgetown University School of Medicine, Washington, D. C., and chairman of the American Medical Association's Board of Trustees, has been appointed director of the AMA's Division of Scientific Activities. He will assume his new duties in 1963 at such time as he can be relieved of his responsibilities as dean.

Doctor Hussey will administer the programs of seven departments with more than 130 employes and an annual budget in excess of $2,000,000. These departments include Foods and Nutrition, Drugs, Rehabilitation, Medical Education and Hospitals, Nursing, Scientific Assembly and Advertising Evaluation.

Sex Differences in Acute Myocardial Infarction

In a study of 77 patients with fatal acute myocardial infarction on whom autopsies were performed from 1955 to 1960, 67.5 per cent were men and 32.4 per cent women. The study failed to reveal any significant shift away from the greater incidence of acute myocardial infarction in the male sex. — Condensed from article by SIDNEY H. TABOR, M.D., *New York State Journal of Medicine*, 62:2336, 1962.

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Brief and to the Point

NAMED PRESIDENT-ELECT—Reed O. Dingman, M.D., Ann Arbor, is the new president-elect of the American Society of Plastic and Reconstructive Surgery, chosen at the annual meeting in Honolulu. Doctor Dingman will assume the presidency of the Society in Washington, D. C. next year.

* * *

LEADER—T. B. Mackie, M.D., Sault Ste. Marie, is chairman of the Chippewa County Heart Unit of the Michigan Heart Association. At the fall teaching session, Ralph Schlosser, M.D., Grand Rapids, spoke to area doctors and dentists.

* * *

SPEAKER—Muir Clapper, M.D., Detroit, presented a program on "Angina Pectoris and Myocardial Infarction" at the 35th scientific session of the American Heart Association at Cleveland. Doctor Muir, president of the Michigan Heart Association, led a sizeable delegation of Michigan doctors and MHA lay leaders to the meeting.

* * *

HONORED—More than 150 honored Norman F. Miller, M.D., Ann Arbor, at the annual meeting of the Norman F. Miller Gynecologic Society. The Society presented to the University of Michigan a portrait of Doctor Miller.

* * *

NAMED—The American College of Hospital Administrators reports that the following Michigan doctors of medicine have been admitted as nominees, the action taken at its recent convocation in Chicago: Robert A. Clowater, M.D., Muskegon; George H. Phillips, M.D., Jackson.

* * *

PRESIDES—Harold F. Falls, M.D., Ann Arbor, president of the American Association for Research in Ophthalmology, presided at the Association's three-day meeting at the University of Michigan in December. The program, which drew about 100 doctors and scientists, included 24 scientific papers and a symposium.

* * *

ON S.S. HOPE—Walter Z. Rundles Sr., M.D., Flint, is serving on the S.S. Hope Ship in Peru. Doctor Rundles joined the ship early in December.

* * *

KELLOGG GRANT—A grant exceeding $1,000,000 has been made by the W. K. Kellogg Foundation to Brown University for support of the University's new program in medical education. Funds will be used for planning and program operation, and for one-third of the cost of a new building planned for a Center for Biological and Medical Sciences.





Photomotograph

A five-minute test with the Burdick Photomotograph indicates the patient whose record is shown above is hypothyroid. The entire procedure for this reliable diagnostic test for thyroid dysfunction — *positioning the patient, connecting the photomotograph to the electrocardiograph, tapping the Achilles tendon, checking the results* — takes but a few minutes, and the record is available for immediate diagnosis and permanent filing.

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OFFERS YOUTH FITNESS REPORT—Physicians interested in a detailed report on the Pilot Study of the President's Council on Youth Fitness, conducted in the fall of 1961 in Muskogee, Oklahoma schools by the East Central Oklahoma Medical Society, may obtain copies on request from Rystan Company, Mount Vernon, New York.

* * *

EXAM SCHEDULED—The American Board of Obstetrics and Gynecology will hold the next scheduled examination (Part II), oral and clinical, for all candidates at the Edgewater Beach Hotel, Chicago, April 29-May 4, 1963. Current Bulletins outlining the requirements for application, may be obtained from Office of the Secretary: Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6.

* * *

HONORED—An oil portrait of Howard B. Barker, M.D., Pontiac, was hung recently in the new doctor's lounge at The William Beaumont Hospital in Royal Oak. The portrait is the work of Robert Thom, noted Bloomfield artist. Doctor Barker was on the original medical advisory committee of Beaumont, was the first chief of staff and has been chief of surgery since the hospital opened.

* * *

ELECTED—The new president of the Ingham Society for Crippled Children and Adults is George A. Sherman, M.D., Lansing. Richard W. Pomeroy, M.D., Lansing, was re-elected to the board also at the annual meeting.

* * *

SERVED IN INDIA—John Ditzler, M.D., Grosse Pointe, is back after a short term near Bombay to help launch a Presbyterian medical school there. He also attended the meeting of the World Medical Association in New Delhi.

* * *

FUNDS FOR MSU—A National Science Foundation grant of $1,213,000 toward construction and furnishing of a new biochemistry building has been accepted by the Michigan State University Board of Trustees. The planned five-story building will cost about $5.2 million, with additional funds anticipated from another federal agency and a private foundation. The new building is part of the MSU plans to develop a two-year preclinical medical program.

* * *

JOINS MHS BOARD—Milton J. Drake, senior vice-president of The Detroit Bank and Trust Company, was elected a public member of the Michigan Blue Cross Board of Trustees. He replaces Hubert Bates, Lansing banker, who asked that his resignation be accepted recently because of press of business commitments.

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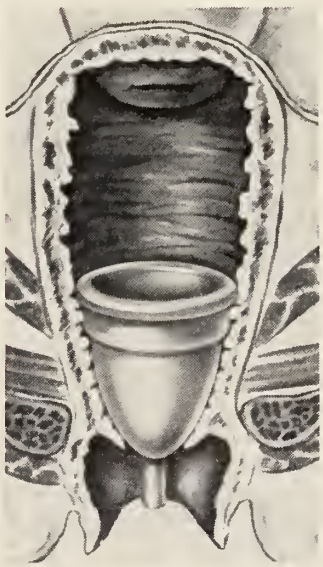
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Ref: Pena, E.F., Obst. & Gynec., *19*:794, 1962. Karnaky, K.J., Obst. & Gynec., *19*:688, 1962. Pena, E.F., Obst. & Gynec., *19*:684, 1962. Karnaky, K.J., Tri-State M.J. Sept., 1961. Burrus, S. Jr., Am. J. Obst. & Gynec. *80*:390, 1960. Karnaky, K.J., Tri-State M.J. Aug. 1960. Karnaky, K.J., Tri-State M.J., June, 1960. Liswood, R., Cur. Med. Dig., *26*:92, 1959. Schaefer, G., Clin. Obst. & Gynec., *2*:535, 1959. Liswood, R., Obst. & Gynec., *13*:539, 1959. Dickinson, R.L., JAMA, *128*:490 (June 16) 1945. Biskind, Mod. Med., *22*:128 (June 15) 1954.

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SERVED IN AFRICA

A young doctor from Zeeland, Michigan, now serving his internship at Butterworth Hospital in Grand Rapids, expanded his medical knowledge and know-how in a unique manner before receiving his M.D. degrèe from the University of Michigan Medical School.



Ryan Tolsma, M.D., Zeeland, assisted for 12 weeks at Takum Christian Hospital in the northern part of Nigeria, a former British colony and now an independent country of West Africa.

Doctor Tolsma, who was born in The Netherlands, and who is a graduate of Calvin College, was one of 33 medical students who received a Smith Kline & French Laboratories Foreign Fellowship this year.

Takum Christian Hospital is operated by the Christian Reformed Church Branch of Sudan United Missions, and Dr. Tolsma is the third young man to be permitted to serve at the hospital through the Smith Kline & French program. Dr. Tolsma assisted in the outpatient clinic.

Dr. Tolsma declared that "it was a real privilege to participate in healing in a place where few were qualified to do that task." And he added that he was "impressed by the patience and friendliness" of the Nigerians in the face of the difficult living conditions which confront them.

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GOES WEST—Jack Edward Berk, M.D., Detroit, became chairman of the department of Medicine at the California College of Medicine January 1. Doctor Berk was clinical professor of medicine at Wayne State University College of Medicine, having taught internal medicine and gastroenterology at the Detroit institution since 1954. He also was director, department of medicine, Sinai Hospital of Detroit; attending physician, Detroit Receiving Hospital; and consultant, Veterans Administration Hospital, Dearborn.

* * *

APPOINTED TO ADVISORY COUNCIL—V. Everett Kinsey, M.D., Grosse Pointe, was one of three medical scientists appointed by Surgeon General Luther L. Terry of the U. S. Public Health Service to a 12-member advisory council. The council serves in an advisory capacity to the surgeon general and the NINBD in awarding grants to medical schools, universities, hospitals and other non-profit institutions for research or training in the field of neurological and sensory disorders.

* * *

AWARDED PRIZE—Elliot D. Luby, M.D., Detroit, won the gold prize of the American Academy of Psychosomatic Medicine, presently meeting in Minneapolis, for a paper entitled, "An Overview of Psychosomatic Disease." The award was the first prize in an annual essay competition.

* * *

SPEAKS—A postgraduate conference on pediatric surgical problems held at the State University of Iowa College of Medicine in December featured Clifford D. Benson, M.D., Detroit, as a guest faculty member.

* * *

WAYNE RESEARCH—The Wayne State University Board of Governors recently accepted a $68,930 grant from the U. S. Public Health Service to Walter H. Seegers, M.D., Grosse Pointe, for continuing his research on prothrombin, one of the clotting factors in blood. The Upjohn Company also granted $5,000 for Dr. Seegers' blood coagulation studies.

The U. S. Public Health Service also gave $7,992 to Adrian C. Kuyper, M.D., Grosse Pointe Farms, for research on the chemistry of bone salt formation.

Harper Hospital gave $18,020 for the Department of Medicine Training Program Fund.

* * *

OFFER SCHOLARSHIPS—The State Board of Alcoholism will offer scholarships to the Rutgers Summer School of Alcohol Studies, June 20 to July 25, at Rutgers, New Brunswick, New Jersey, and at the

Midwest Institute at Western Michigan University, Kalamazoo, June 17-21. The purpose of these schools is to study and investigate the various aspects of the problems of alcohol as they affect our society and the individuals within it. Applications for scholarships can be obtained from George H. Stewart, Education Director, State Board of Alcoholism, 230 North Grand Avenue, Lansing.

* * *

RECOGNITION—The efforts of McClelland B. Conover, M.D., Flint, in the field of rehabilitation of the physically handicapped were recognized recently at Flint. A special award was presented by the Flint Committee to Promote Employment of Handicapped Persons.

* * *

GETS GRANT—The work of John Stirling Meyer, M.D., Detroit, in cerebrovascular research is being supported by a recent grant of $204,000 by the U. S. Public Health Service to Wayne State University.

* * *

THREE AWARDS—The American Society for the Study of Sterility will present three awards at its annual meeting in New York, April 19, 20 and 21. Details about two cash awards and a grant-in-aid may be obtained from Michael Newton, M.D., Chairman, Awards Committee, American Society for the Study of Sterility, 2500 North State Street, Jackson 6, Mississippi before March 1.

* * *

SEMINAR LEADERS—Co-chairmen for the national Third Annual Burn Conference at the University of Michigan were Irving Feller, M.D., and Marvin S. DeWeese, M.D. Representatives of 15 institutions participated.

* * *

TOWN SAYS THANKS—A community observance recently helped to honor J. C. Webster, M.D., of Marlette, for his more than 50 years of medical service. He received a plaque denoting lifetime membership in the Sanilac County Medical Society.

* * *

CITED BY CHURCH—"Layman of the Year" was the award given recently to George C. Hardie, M.D., by the Jackson First Presbyterian Church. An elder of the church for more than 25 years, Doctor Hardie was cited especially for serving recently in West Africa as a volunteer eye surgeon at a mission hospital.



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SKI ENTHUSIAST—President of the Lansing Ski Club is James Wainwright, M.D., who directed a busy fall improvement program on the 40 acres of club hills and on the clubhouse.

* * *

OUTSTANDING—Many honors are won regularly in ice skating competition by the children of Michigan doctors. Going up the ladder in world figure skating competition are Janet and Nic Burhans, children of Dr. and Mrs. R. A. Burhans of Lansing; Joanne Heckert, daughter of Dr. and Mrs. J. K. Heckert of Lansing; and Timothy Wood, son of Dr. and Mrs. K. A. Wood of Detroit.

* * *

HONORED—Milton A. Darling, M.D., Detroit, Past President of the Michigan State Medical Society, has been elected President of the Yates Memorial Clinic. Also elected to office was Gerald S. Wilson, M.D., Detroit, vice president in charge of research. Re-elected also was E. Eric Muirhead, M.D., Detroit, vice president. Re-elected for three-year terms as trustees were Doctor Darling, Doctor Wilson, Harry M. Nelson, M.D., Detroit, and Norman D. Nigro, M.D., Detroit.

* * *

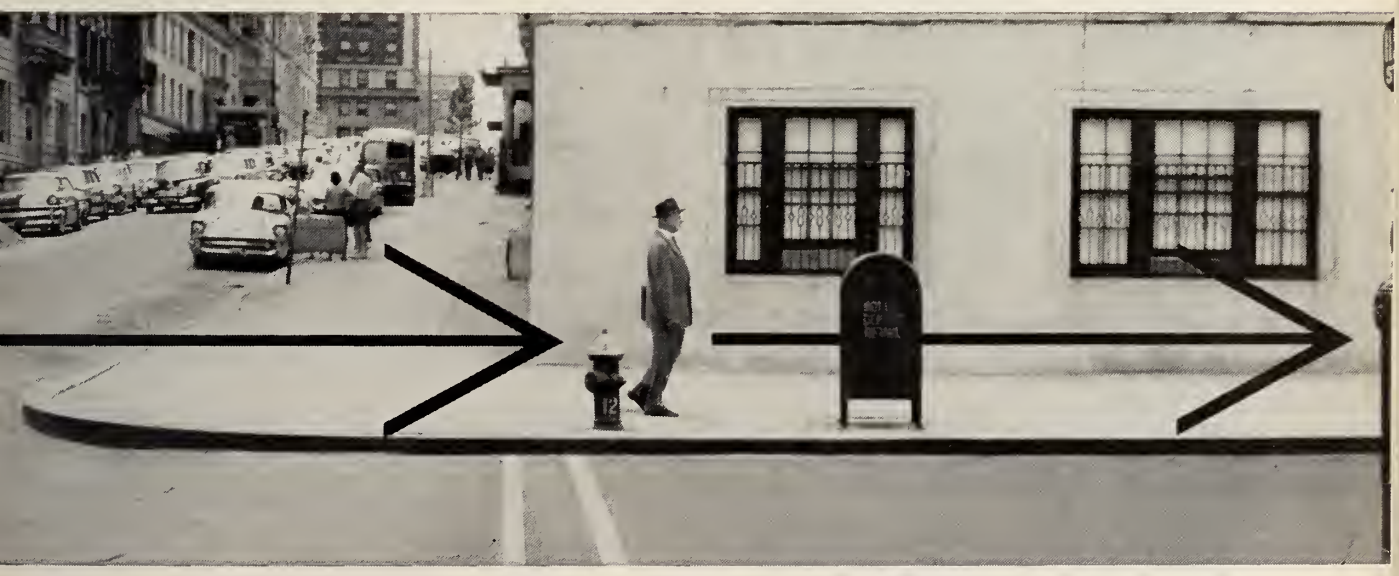
BEGIN WSU BUILDING—Groundbreaking for Wayne State University's Medical Research Building, the first building to occupy the new University Medical campus, was held November 20.

Located on a site bounded by St. Antoine, Willis, Beaubien and Canfield, the $3,680,417 building is scheduled for completion in the spring of 1964.

The four-story Medical Research Building is the first of five large research structures planned on the medical campus site. State Legislature funds will account for $2,250,000 of the building cost, with $1,430,417 coming from the National Institutes of Health.

* * *

CHOSEN FOR MMS BOARD—The Board of Directors of Michigan Medical Service has elected Irving B. Bluestone, Walter Reuther's administrative assistant, to the seat vacated when Jerome Pollock, UAW-CIO economist, was appointed to the teaching staff of Columbia University.



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MEETINGS USA

March

American Academy of Allergy, The Queen Elizabeth, Montreal, Quebec, March 12-14; Paul M. Seebohm, M.D., University Hospital, Iowa City, Secretary.

American College of Allergists Graduate Instructional Course and Nineteenth Annual Congress, March 24-29, Americana, New York; John D. Gillaspie, M.D., Treasurer, 2141 14th St., Boulder, Colorado.

American Academy of General Practice, Chicago, March 29-April 5; Mac F. Cahal, J.D., Volker Blvd. at Brookside, Kansas City 12, Exec. Dir.

American Industrial Health Conference, Park-Sheraton Hotel, Washington, D. C., March 18-21; write to 55 East Washington, Chicago 2.

American Medicolegal Symposium, American Hotel in Miami Beach, March 8-9; write to C. Joseph Stetler, AMA, for details.

American Society of Internal Medicine, Brown Palace, Denver, March 29-31; Albert Whitehall, 3410 Geary Blvd., San Francisco 18, Exec. Dir.

April

Aerospace Medical Association, Statler-Hilton Hotel, Los Angeles, April 29-May 2; Wm. Kennard, M.D., Aerospace Medical Ass'n, National Airport, Washington, D. C.

American Academy of Neurology, Leamington Hotel, Minneapolis 17, April 22-27; C. A. Kane, M.D., 80 E. Concord, Boston.

American Association of Pathologists & Bacteriologists, Netherlands Hilton, Cincinnati, April 26-28; John R. Carter, University of Kansas Medical Center, Kansas City 3.

American Association for Thoracic Surgery, Shamrock Hilton, Houston, April 8-10; Henry T. Bahnson, M.D., Johns Hopkins Hospital, Baltimore 5.

American College Health Association, Meuhlebach Hotel, Kansas City, April 23-26; Ruth E. Boynton, M.D., 5513 Merrick Dr., Coral Gables 46.

International College of Surgeons (North American Federation) Congress; Ambassador Hotel, Los Angeles, April 21-25; W. F. James, M.D., 1615 Lakeshore Drive, Chicago 10, Executive Director.

American College of Obstetricians and Gynecologists, Statler Hilton, New York, April 21-24; Graig W. Muckle, 1806 Garrett Rd., Lansdowne, Pa.

American College of Physicians, Denver-Hilton, Denver, April 1-5; Edward G. Rosenow, Jr., M.D., 4200 Pine St., Philadelphia 4.

American Dermatological Association, The Homestead, Hot Springs, Va., April 15-18; Wiley M. Sams, 309 Ingraham Bldg., Miami 32.

American Otological Society, Hollywood Beach Hotel, Hollywood, Fla., April 26-27; James A. Moore, 535 E. 68 St., New York 21.

American Physiological Society, Ambassador, Atlantic City, April 16-20; R. G. Daggs, 9650 Wisconsin, Washington 14, D. C.

American Radium Society, Mark Hopkins Hotel, San Francisco, April 1-4; Mustin J. Stein, M.D., University of California, Los Angeles.

American Surgical Association, Westward Ho Hotel, Phoenix, April 3-5; W. A. Altemeier, Cincinnati General Hospital, Cincinnati 29.



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Association of American Physicians, Chalfonte-Haddon Hall, Atlantic City, April 20-May 1; Eugene A. Stead, Jr., Duke Hospital, Durham, N. C.

Iowa Medical Society, Savery Hotel, Des Moines, April 21-24; Mr. D. L. Taylor, 529 36th St., Des Moines 12, Iowa.

May

American Gynecological Society, Roosevelt Hotel, New Orleans, May 13-15; C. J. Lund, 260 Crittenden Blvd., Rochester, N. Y.

American Ophthalmological Society, The Homestead, Hot Springs, Va., May 27-29; Joseph Wadsworth, M.D., 108 East 68th St., New York 21.

American Pediatric Society, Seaside Hotel, Atlantic City, May 3-4; Conrad M. Riley, 2800 E. Cedar, Denver 9.

American Proctologic Society, St. Francis Hotel, San Francisco, May 20-23; Norman D. Nigro, M.D., 7815 E. Jefferson, Detroit 14.

American Psychiatric Association, Chase Park Plaza, St. Louis, May 6-10; Harvey J. Tompkins, 114 W. 12th St., New York 11.

American Thoracic Society, Denver-Hilton, Denver, May 13-15; Frank W. Webster, 1790 Broadway, New York 19.

American Urological Association, Hotel Sheraton-Jefferson, St. Louis, May 13-16; Wm. P. Didusch, 1120 N. Charles, Baltimore 1.

Student AMA, Sherman Hotel, Chicago, May 2-4; write Executive Director R. F. Staudacher, 333 N. Michigan, Chicago, Ill.

Michigan Authors

William J. McElroy, M.D., Royal Oak, "The Low Back Problem: A Revised Approach," *Industrial Medicine and Surgery*, August, 1962.

Carey P. McCord, M.D., Ann Arbor, "The Occupational Toxicity of Cultivated Flowers," *Industrial Medicine and Surgery*, August, 1962.

Andrew J. Zweifler, M.D., Ann Arbor, "Relation of Prothrombin Concentration to Bleeding During Oral Anticoagulant Therapy," *The New England Journal of Medicine*, August 9, 1962.

F. M. Davenport, M.D., Ann Arbor, "Current Knowledge of Influenza Vaccine," *Journal of the American Medical Association*, October 6, 1962.

Traian Leucutia, M.D., Detroit, "Ionizing Radiations in Our Era," *Journal of the Americal Medical Association*, October 6, 1962.

Harold H. Gay, M.D., Midland, "Blood and Urinary Levels Following Exposure to Bromides," *Industrial Medicine and Surgery*, October, 1962.

Stanley H. Schuman, M.D., Ann Arbor, "Host Factors and Environment in Studies of Human Sweat," *Industrial Medicine and Surgery*, October, 1962.

Leonard Himler, M.D., Ann Arbor, "Psychiatry in Industry," *Industrial Medicine and Surgery*, October, 1962.

Irving I. Edgar, M.D., Detroit, "Superstition and Etiology in Medicine," *Medical Times*, October, 1962.

John G. Batsakis, M.D. and **Ronald H. Nishiyama, M.D.,** Ann Arbor, "Deafness with Sporadic Goiter," *Archives of Otolaryngology*, November, 1962.

IN MEMORIAM

LEO F. CHESS, M.D., 61, Reed City physician since 1928, died November 15, 1962.

A 1927 graduate of the University of Iowa Medical School, Doctor Chess served his internship at Butterworth Hospital, Grand Rapids, before establishing his practice in Reed City. He was on the staff of the Reed City Hospital.

BARNEY A. CREDILLE, M.D., 72, Flint allergist since 1925, died November 3, 1962.

A 1918 graduate of Tulane University medical school, Doctor Credille served his internship and residency with the U. S. Public Health Service in the Panama Canal Zone, before coming to Flint.

Doctor Credille was chief of the St. Joseph Hospital Allergy Department from 1942 to 1946 and held a similar position at Hurley Hospital in 1948 and 1949. He was a past president of the Michigan Allergy Society and the Flint Academy of Medicine, and a Life member of the Michigan State Medical Society.

WILLARD B. HOWES, M.D., 77, Royal Oak, died October 26, 1962.

A 1912 graduate of Boston University Medical School, Doctor Howes had been a Royal Oak resident since his retirement five years ago. He was medical director of the Detroit Tuberculosis Sanatorium for a number of years and prior to that was superintendent of Worcester State Hospital in Massachusetts. He was a member of the American College of Chest Physicians and a Life member of the Michigan State Medical Society.

HIPPOCRATES M. KYPRIE, M.D., 69, Detroit practitioner since 1918, died November 20, 1962.

A University of Michigan Medical School graduate, Doctor Kyprie was an Associate member of the Michigan State Medical Society.

FRANK W. OSTRANDER, M.D., 82, Freeland physician, died Noyember 8, 1962.

A 1901 graduate of the former Saginaw Valley Medical College, Doctor Ostrander was a Life member of the Michigan State Medical Society.

HENRY L. ULBRICH, M.D., 79, Detroit physician, who recently had completed his 50th year in practice, died November 10, 1962.

Doctor Ulbrich, the first physician to operate X-ray equipment in Detroit, was on the staffs of St. Joseph Mercy and Deaconess Hospitals. Memberships included the Detroit Roentgen Ray and Radium Society, Michigan Society of Roentgenologists and American College of Radiology. He was a Life member of the Michigan State Medical Society.

FREDERICK BURNELL WIGHT, M.D., 67, Detroit and Yale obstetrician and gynecologist since his 1921 graduation from University of Michigan Medical School, died November 25, 1962.

Doctor Wight was on the staffs of Crittendon General and Woman's Hospitals.

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Cites Needs for Long-Term Care

Greater federal involvement in medical care programs for the aged in the near future has been predicted by Thomas Fitzpatrick, acting director of the University of Michigan Program in Hospital Administration.

"Long-term care of patients constitutes the most serious deficit in health care in Michigan and the nation," he told a recent Nursing Home Administrators Conference at Michigan State University.

"Demand is increasing for more federal aid in this area," he said, "and the demands will result in legislation."

"There will soon be," Mr. Fitzpatrick stated, "federally financed programs for the aged more comprehensive than the Kerr-Mills Bill, or perhaps a significant expansion of benefits under that bill."

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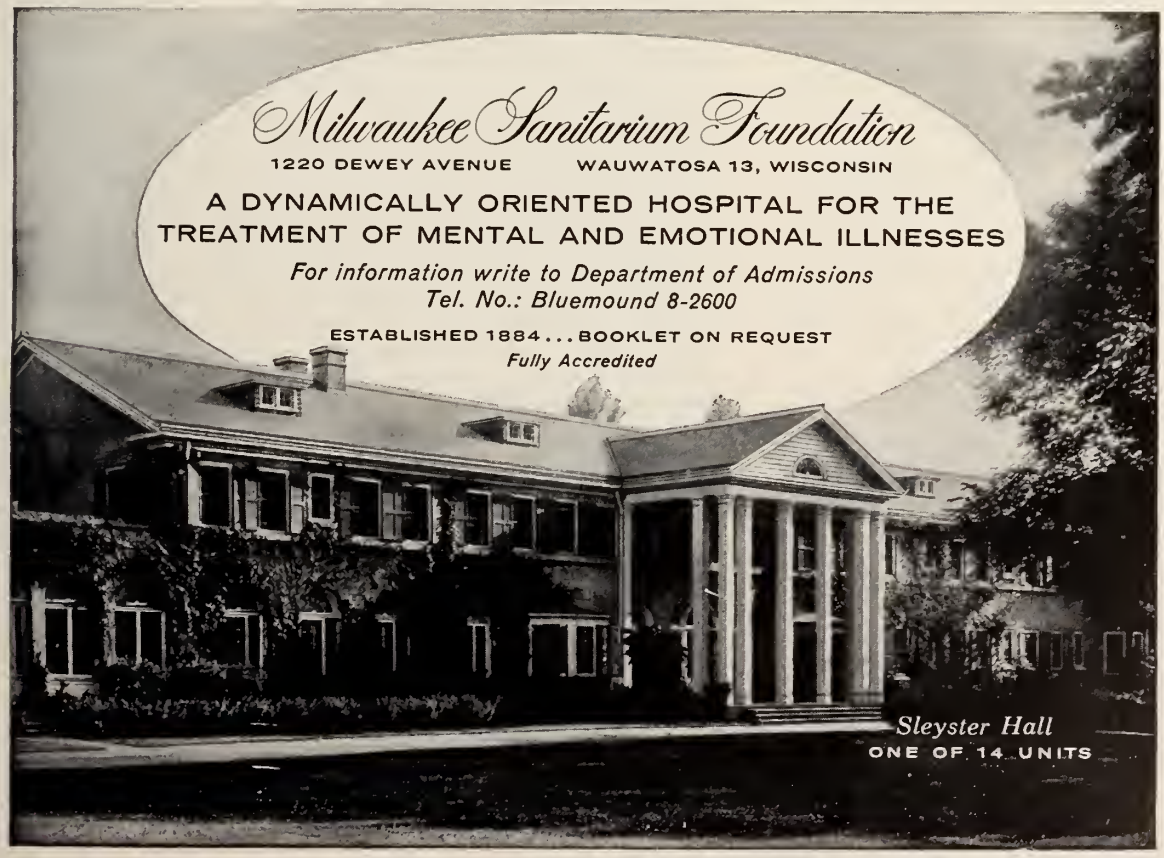
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Letters to the Editor

Editor,
Journal Michigan State Medical Society

Dear Sir:

I read with horror the editorial on Thalidomide and Pharmaceutical Manufacturing in the September issue. The entire world looks upon the Thalidomide episode as one of the most shameful events in the history of the pharmaceutical industry and you attempt to pass it off as "just one of those things."

Your editorial expresses not one word of concern for the parents of children who have been born with horrible deformities, but you shed crocodile tears for the pharmaceutical houses and the tremendous expense to them in recalling and destroying the drug. I am sure you have not done your homework in the preparation of this editorial or you would have known that the drug house responsible was doing everything it could to get Thalidomide approved even after it was known that toxic effects had been reported in Europe. The entire history of this case is well documented and is available for your perusal.

What makes your editorial even more reprehensible is that you use it to make a derogatory remark about Senator Estes Kefauver because his committee was in part instrumental in protecting the American public against some of the questionable practices in the marketing of new untried drugs.

I would hate to think that any one should be influenced in believing that the tone of your editorial represents the doctors' attitude towards this shameful event. If this type of writing is necessary in order to mollify the advertisers in the JOURNAL, it would be far better to discontinue the JOURNAL.

Sincerely yours,
RAYMOND A. SOKOLOV, M.D.

Detroit, Michigan
October 18, 1962

●

Dear Editor:

On behalf of our Health Education Curriculum Committee, I want to thank you sincerely for the copies of your September JOURNAL which you so graciously made available to us at our recent meeting.

Members of the Committee were extremely interested in the articles which appeared in this issue having to do with physical education, health, and fitness, and I know that they will want to keep these copies as important additions to their health reference libraries.

J. J. HARRIS, *Chief*
Trade and Industrial Education
Michigan Department of Public Instruction

Lansing, Michigan

Michigan State Medical Society:

The question has been raised in Michigan about the storage of medical credentials for safekeeping during a national emergency.

The World Medical Association, 10 Columbus Circle, New York 19, New York, operates a central repository for the storage and safekeeping of medical credentials. Photostats, microfilms, or notorized copies of original medical school records, medical diplomas, and specialist credentials may be deposited for safekeeping. The AMA approves the objective of a central repository and has publicized the facilities that are available through the World Medical Association.

For additional information on this subject, I suggest that the World Medical Association be contacted.

FRANK W. BARTON, *Director*
Department of National Security
American Medical Association

●

Michigan State Medical Society:

Let me compliment you on the production of a fine MSMS Annual Report which would do credit to any corporation. It befits our Medical Society, as well as the leaders to have so nice a presentation.

M. K. NEWMAN, M.D.

Detroit, Michigan

X-RADIATION CONTROL

(Continued from Page 96)

people of more than a million roentgens over the course of the past year. Upon completion of the program it is estimated that the amount of radiation reduced will exceed 2.5 million roentgens per year. Although this reduction of radiation cannot be directly related to the saving of lives, it is well established that the effects of radiation exposure to individuals are cumulative. Thus any reduction in unnecessary exposure to radiation must be considered beneficial to the public at large. Unquestionably, the reduction of radiation is of direct benefit to those people who are in daily proximity to x-ray machines particularly the x-ray technicians. In fact, the amount of radiation to which technicians are exposed has been reduced to a practical minimum even though the exposure before adjustments were made was not above permissible levels.

Through our program to control unnecessary radiation emitted from x-ray machines, the Department hopes to be able to reduce to a minimum all scatter or excess radiation emitted by x-ray machines in physicians' offices and clinics. This program is yet another example of the cooperation between public health specialists and private physicians toward better health protection for all Michigan people.

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Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

BOOKS RECEIVED

NUTRITION IN A NUTSHELL. By Roger J. Williams. Illustrations by Nell Taylor. Dolphin Books, Garden City, New York: Doubleday & Company, Inc., 1962. Price, 95 cents.

CURARE AND CURARE-LIKE AGENTS. By Ciba Foundation Study Group No. 12, in honor of Professor C. Chagas. Editor for the Ciba Foundation; A.V.S. De Reuck, M.S.C., D.I.C., A.R.C.S. 26 Illustrations. Boston: Little, Brown and Company, 1962. Price, $2.95.

DOCTORS, PATIENTS, AND HEALTH INSURANCE. The Organization And Financing of Medical Care. By Herman Miles Somers and Anne Ramsay Somers, Abridged Edition. Anchor Books. Garden City, New York: Doubleday & Company Inc., 1962. Price, $1.95.

CORRELATIVE NEUROANATOMY AND FUNCTIONAL NEUROLOGY. By Joseph G. Chusid, M.D., Associate Director, Neurological Division, St. Vincent's Hospital, New York Clinical Associate Professor of Medicine (Neurology) Seton Hall College of Medicine and Dentistry, Jersey City, New Jersey, and Joseph J. McDonald, M.D., Dean of the School of Medicine, American University of Beirut, Beirut Lebanon, formerly Professor of Surgery, Columbia University, New York. Eleventh Edition. Los Altos, California: Lange Medical Publications, 1962. Price, $5.50.

THE ACHILLES REFLEX TEST (ART) IN THE DIAGNOSIS OF THYROID DYSFUNCTION. By Maurice B. Gordon. Manhasset, N.Y.: Romaine Pierson Publishers, Inc., 1962. Price, $1.00.

THE SCIENCE OF DREAMS. By Edwin Diamond. Garden City, New York: Doubleday & Company, Inc., 1962. Price, $4.50.

THE LIFE OF DR. SAMUEL A. MUDD (revised). By Nettie Mudd. 363 pages. Private printing, republished by Dr. R. D. Mudd, 1962.

The story of Dr. Samuel A. Mudd—and the efforts of his grandson, Richard D. Mudd, M.D., of Saginaw, to completely exonerate him—is a familiar one in Michigan.

It was Dr. Samuel Mudd who treated John Wilkes Booth after his leg was broken in the assassination of Abraham Lincoln. During the highly emotional aftermath, Doctor Mudd was sentenced to life imprisonment at Fort Jefferson in Florida Keys, gallantly treated the sick when yellow fever struck the garrison, then was pardoned after four years' detention.

Despite the pardon, Dr. Richard Mudd sought for many years to vindicate his grandfather.

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M. Bentley, eventually resulted in a bill in Congress to erect a monument honoring Dr. Samuel Mudd near Ft. Jefferson. This, the Saginaw physician believes, not only completely clears his grandfather, but proves that he was convicted unjustly. The monument was dedicated May 11, 1961.

"The Life of Dr. Samuel A. Mudd" was written by one of his nine children, Mary Eleanor (Nettie) Mudd, an aunt of Dr. Richard Mudd, and was published by the Neale Publishing Company in 1906. Nettie Mudd died in 1943. The recent current edition was published privately by Dr. Richard Mudd.

New pictures and materials have been added, including collection of letters not in the earlier edition and a list of the descendants of Dr. Samuel Mudd.

ENZYMES AND DRUG ACTION. Ciba Foundation Symposium jointly with Co-ordinating Committee for Symposia on Drug Action on Enzymes and Drug Action. Editor for the Co-ordinating Committee: J. L. Mongar, PH.D. Editor for the Ciba Foundation: A. V. S. de Reuck, M.SC., D.I.C. 90 illustrations. Boston: Little, Brown and Company, 1962. Price, $12.50.

Following the usual format of other Ciba Symposia, 71 international authorities discuss the advances in enzyme chemistry, likely to figure in future advances in pharmacology, Proceedings are presented with a minimum of editing. Each paper is followed by general discussion.

A wide range of topics, including inhibition of acetylcholinesterase, explanation of the action of insulin on sugar permeability at molecular level, mechanisms of digitalis action, drug tolerance, and many others are discussed.

This book is primarily for workers in the basic sciences, biochemistry and pharmacology, who are engaged in basic research, but carry some general interest.

ROBERT W. BROWN, M.D.

THE DYNASTY. By Charles H. Knickerbocker. A Medical Novel. Garden City, New York: Doubleday & Co. Inc., 1962.

This is a medical novel which tells the story of a powerful family of doctors who have dominated the profession in the small town in which they live and of the challenge to this domination by a young doctor, with ideals, who marries into the family and comes to practice with the wife's father.

This book brings to the forefront many factors in the doctor-patient relationship which bothers both patients and physicians today, and portrays the success of a practitioner who exploits personality and the art of medicine over science for the greater financial reward, a condition all too common in modern day practice.

It is interesting and rather well written, and is better than the usual novel written by a physician.

ROBERT W. BROWN, M.D.

TOMORROW'S MIRACLE. By Frank G. Slaughter. Garden City, New York: Doubleday & Company, Inc., 1962. Price, $3.95.

This is a medical novel by a well known author, which represents a series of flash-backs covering the career of a young medical student and physician, of devious back-

ground, who becomes a Missionary-Doctor in French Guiana. Emphasizing the self-sacrifice of the principal figure and his several romances, it takes on many of the attributes of the usual soap-opera, with many tense and dramatic moments, in a jungle background.

ROBERT W. BROWN, *M.D.*

EARLY DETECTION AND DIAGNOSIS OF CANCER. By Walter E. O'Donnell, M.D., Emerson Day, M.D., F.A.C.P., and Louis Venet, M.D., F.A.C.S. 82 figures and 3 color plates. Saint Louis: The C. V. Mosby Company, 1962. Price, $12.00.

A very well-written manual for all who have any interest in cancer diagnosis. Most of it is in outline form, it is concise with full coverage of cancer diagnosis in all areas. The line drawings are good and clearly explain the various methods and procedures recommended. Statistical tables render this a valuable reference book and relate to incidence, mortality, rates, ratios, age, geographic distribution, and recent trends in cancers in various organs. Brief comments are made on classification, etiology, and screening procedures.

A.A.H.

DIAGNOSIS AND THERAPY OF THE GLAUCOMAS. By Bernard Becker, M.D., Professor and Head of the Department of Ophthalmology, Washington University School of Medicine, St. Louis, Mo. and Robert N. Shaffer, M.D., F.A.C.S., Associate Professor of Ophthalmology, University of California School of Medicine, San Francisco, Calif. 230 illustrations and 5 plates in color. St. Louis: The C. V. Mosby Company, 1961. Price, $18.00.

The authors have produced a very elaborate, well-illustrated and well-constructed book on the glaucomas. They stress tonotomy, measuring of tension, quite extensively and they go into much detail in the extension of pain through the trigeminal region and its relief or partial relief by medication. Medical and surgical techniques are very elaborately described. This is a very worthwhile book.

SYSTEM OF OPHTHALMOLOGY. Edited by Sir Stewart Duke-Elder Vol. VII. The Foundations of Ophthalmology—Heredity, Pathology, Diagnosis and Therapeutics. 471 illustrations and 11 colored plates. St. Louis: The C. V. Mosby Company, 1962. Price, $30.00.

This book, edited originally by Sir Stewart Duke-Elder, is one of fifteen volumes of over 800 pages. This particular book is Volume VII. The whole series is being re-issued, brought up to date. This book, printed in England, is undoubtedly the most ambitious account of ophthalmology ever attempted and constitutes an exquisite reference book. The wealth of material in it would make it impossible for any person to completely digest and assimilate the material. It is probably one of the most prized works in the ophthalmological field.

Wise Verse

Elliott Joslin, M.D., famed fighter against diabetes, had this verse inscribed on a wall at the Deaconess Hospital in Boston:

Who learns and learns,
Yet does not what he knows
Is one who plows and plows
Yet never sows.

Editorial Comment

It's the Vote that Counts

(New York State Journal of Medicine)

In the unfortunate event that the American people become the victims of some universal health plan under government control, it might well be described by some future historian as follows:

Socialized medicine came to these United States in the middle of the 20th century:

not as a result of the piteous demands of a large segment of the population left to suffer and die because of lack of funds, until government had no recourse but to establish it;

not because of the brilliant campaign and arguments of its socialistic proponents;

and not due to the demands of a medical profession infested by that strange epidemic of the period characterized by complete absorption in and almost fanatic veneration of security;

but it did come about through this commonplace happenstance: though man as he ages loses his teeth, hair, and at times his memory, he never loses his vote.

Federal-Level Health Waste Is Criticized

By LYLE C. WILSON, *United Press International*, November 17, 1962

Boondoggling is being done in the semi-sacred precincts of the National Institutes of Health. The institutes have a special place in the republic, like the institution of matrimony, motherhood and the FBI. Attack NIH at your peril because who could be against health, especially national health? Nobody, that's who!

Sen. Paul Douglas, D-Ill., took on the NIH during the last session with more and better basic material than the Department of Agriculture provided Pat Harrison 30-odd years ago. But Paul Douglas is not Pat Harrison. Too serious, for one thing, with his professional background whereas Pat was flip and sarcastic as a one-time news boy should be, especially after a political lifetime of enticing votes in the Mississippi boondocks.

Tax Foundation, Inc., of New York, exhumed Douglas' effort from the Congressional Record. It disclosed that NIH spent $13,837 on "Investigation of Information Contained in Echoes." Its "Studies of Silent Thinking" tapped the taxpayers for $26,565. "The Stereostatic Atlas of the Beagle Brain" was more like a bargain, $9,775. "Tooth Development in Sheep" was almost a giveaway at $2,300.

Cat fanciers probably will applaud NIH expenditures of $19,965 on a study of "Red Tuna and Yellow Fat Disease in the Cat." Our distant neighbors to the northeast will be grateful to U.S. taxpayers for putting up $14,000 for a study of "The Oral Health of Icelandic People."

The Tax Foundation's report suggests that NIH is one of the spoiled brats of our Federal bureaucracy. Congress habitually votes NIH more money than is budgeted, a lot more. The budget figure increased from $190.2 millions in 1958 to $400 millions in 1961. Appropriations ranged from 1958's $211.2 millions to 1961's $560 millions.

Perhaps the time has come to reduce the high-off-the-hog standard of living at NIH. The taxpayers could use the money.

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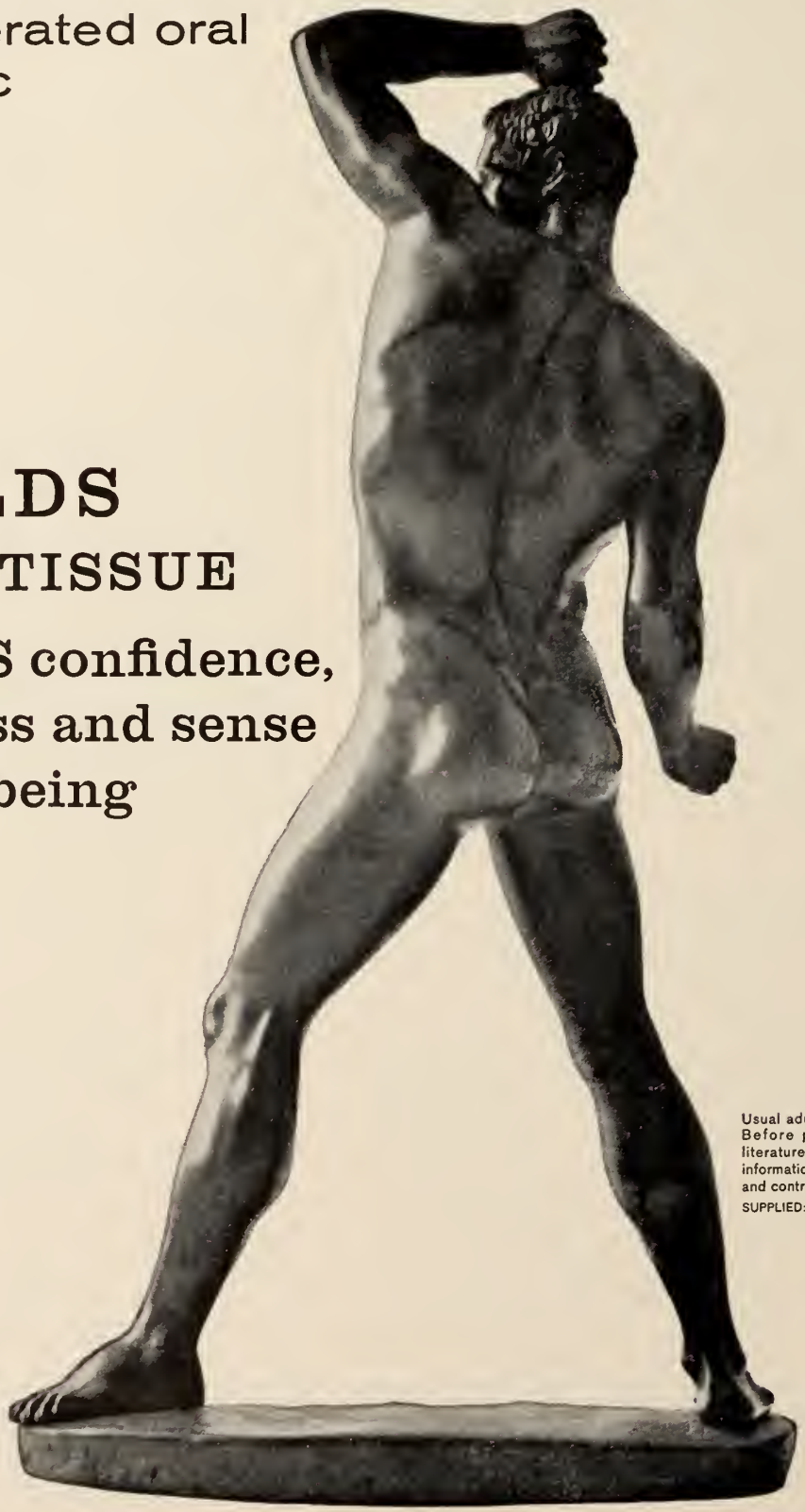
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Michigan State Medical Society
Ninety-Seventh Annual Session
September 23-25, 1962

Digest of Proceedings
of the
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This number is composed of two sections, of which this is Section 2.

Michigan State Medical Society
Ninety-seventh Annual Session
September 23-25, 1962

Digest of Proceedings

MSMS Ninety-Seventh Annual Session--1962
House of Delegates Proceedings

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	(1) Annual and Supplemental Reports of Committee on Medical Socio-Economics	14	52	Approved
	(2) Report of Finance Committee	17	47 & 60	Approved
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X.	*Resolutions*	30		
	1. Medical Care Insurance (Cooper of Wayne)	30	57	Amended and approved in principle
	2. New Poll on Social Security (McLean of Wayne)	30	49	Substitute resolution approved
	3. Establishment of Certain New Classes of Membership (Scoville of Washtenaw)	30	43	Approved in principle and referred to Committee on Constitution and Bylaws
	4. Education of Registered Nurses (Vardon of Wayne)	31	57	Amended and approved in principle
	5. Good Samaritan Legislation (Yott of Wayne)	31	58	Amended and approved
	6. A Tribute to the MSMS Council, the Officers, and the Legal Affairs Committee (Rom of Wayne)	31	49	Approved
	7. Health and Physical Fitness of School Children (Palmer of Wayne)	32	44	Approved
	8. Evaluation of Non-Hospital Medical Care (Rhoades of Wayne)	32	49	Amended and approved
	9. Decision in Appeal Cases (Bailey of Wayne)	32	44	Substitute Resolution approved
	10. Reporting of Venereal Disease (Montante of Wayne)	32	44	Approved
	11. Proposed Changes in Kerr-Mills Law (Furlong of Oakland)	32	52	Supported in principle and referred to Medical Care Insurance Committee

		Introduction of Business	*Reference Committee Report*	*Action*
12.	Surgical Assistants Fee (Slevin of Wayne)	33	53	Substitute Resolution Approved
13.	Mediation Committees (Weed of Wayne)	33	44	Referred to Committee on Constitution and Bylaws
14.	Protective Health Measures for Boxers (Slevin of Wayne)	33	58	Amended and approved
15.	Disciplinary Procedures (Segar of Wayne)	33	44	Referred to Committee on Constitution and Bylaws
16.	Single Medical Practice Act (Ryan of Kalamazoo)	33	58	Amended and approved in principle
17.	Michigan Relative Value Scale (Avery of Kent)	33	52	Substitute Resolution Approved
18.	Including Doctors of Medicine in Old Age Survival Insurance (Pedden of Kent)	34	49	Disapproved
19.	Function of Public Health Service (Perkin of Wayne)	34	58	Amended and approved in principle
20.	Single Medical Practice Act (Howes of Wayne)	34	58	No action
21.	Commendation to American Association of Medical Assistants (Whiteley of Wayne)	34	49	Approved
22.	Change in Duties of MSMS Secretary and of Executive Director (Bailey of Wayne)—see Resolution No. 24	34	44	Approved
23.	Correction in Number of New MSMS Councilors (Rhoades of Wayne)	34	44	Approved
24.	Change in Duties of MSMS Secretary and of Executive Director (Bailey of Wayne)—see Resolution No. 22	35	44	No action
25.	Immunity from Legal Entanglements When Drawing Blood Samples (Ivkovich of Mecosta-Osceola-Lake)	35	58	No action
26.	Proposed Institute of Child Health and Human Development (Cole of Wayne)	35	60	No action
27.	Use of Michigan Relative Value Scale (Taylor of Jackson)	36	52	Amended and approved
28.	Endorsement of HB 39, (re: review of administrative rules) 1962 Regular Session, Michigan State Legislature (Findlayson of Chippewa-Mackinac)	36	58	Amended and approved
29.	Change in Administrative Rules of Michigan Medical Aid to the Aged Act (Findlayson of Chippewa-Mackinac)—see Resolution No. 42	36	53	Approved in principle
30.	Health Insurance Pooling (Wemmer of Calhoun)	36	59	Amended and approved
31.	Get-Out-the-Vote (Wemmer of Calhoun)	36	49	Approved
32.	Social Security Taxes (Blain of Wayne)	37	60	No action
33.	Joint Accreditation Committee Policy (Scoville of Washtenaw)	37	45	Disapproved with the recommendation that No. 33 be re-submitted with more information
34.	Internal Revenue Mechanisms (Scoville of Washtenaw)	37	57	No action
35.	Urging Passage of the Curtis Bill (Scoville of Washtenaw)	37	53	Amended and approved
36.	Extending Good Samaritan Legislation to Cover Hostile Attack or Disaster (Power of Grand Traverse-Leelanau-Benzie)	37	58	Amended and approved
37.	Blue Cross Coverage for MSMS Widows and Families (Power of Grand Traverse-Leelanau-Benzie)	38	53	Amended and approved
38.	Commendation to Lawrence A. Drolett, M.D. (Stow of Ingham)	38	46	Amended and approved
39.	Recommending Membership in the Michigan Association of the Professions to the Michigan State Medical Society Membership (Gwinn of Barry)	38	49	Amended and approved
40.	Physician Membership on Hospital Governing Boards (Dinnen of St. Clair)	38	45	Amended and approved

	Introduction of Business	*Reference Committee Report*	*Action*
41. County Medical Society Nominations to MSMS Committees (Tisdell of St. Clair)	38	49	Approved
42. Implementation of the Kerr-Mills Act (Tallant of Wayne)	39	53	Amended and approved
43. Cash Return from Social Security (Tallant of Wayne)	39	59	Amended and approved
44. Favoring Recognition of General Hospitals of Realistic Size (Johnson, Delegate-at-Large)	39	59	Amended and approved in principle
45. Changes in Football Headgear (Drake of Northern Michigan)	39	44	Amended and approved
46. Psychiatrists on Mental Health Commission (Bauer of Washtenaw)	40	59	Amended and approved
47. Opposing Compulsory Retirement by Reason of Age Alone (Bauer of Washtenaw)	40	45	Approved
48. Disassociation of Blue Shield from Blue Cross in Public Utterances (Lahti of Oakland)	40	50	Disapproved
49. Periodic Readjustment of Unit Value of Relative Value Scale (Lahti of Oakland)	40	52	Amended and approved
50. Opposing Health Care Advisory Committee to State Insurance Commissioner (Johnson, Delegate-at Large)	40	59	Referred to The Council for study and action
51. Broadening of Michigan Foundation for Medical and Health Education, Inc. (Brosius of Wayne)	40	45	Amended and approved
52. Michigan Medical Service Contracts for Persons over Age 65 (Rice of Jackson)	41	53	Amended and approved
53. Emergency Care in Hospitals (Howes of Wayne)	41	45	Amended and approved
54. Correction of Error in MSMS Bylaws (Bailey of Wayne)	41	44	Approved
55. Opposition to Enlargement of Governmental Activities in the Practice of Medicine (France of Wayne)	42	59	Amended and approved in principle
56. National Survey of Kerr-Mills Operation (Howes of Wayne)	42	53	Amended and approved
57. Problems of the Indigent Physician (Swanson of Wayne)	42	50	Disapproved
58. Conduct of Opinion and Information Surveys by the Michigan State Medical Society (Wunsch of Wayne)	42	46	Amended and approved
59. Unemployment and Workmen's Compensation Acts (Darling of Wayne)	42	60	Approved
60. Consolidation of State Health Agencies (McKean of Wayne)	42	44	Approved
61. Driver-Operator License (Beets of Kent)	42	44	Approved
62. Medical Training Facilities in Grand Rapids (Beets of Kent)	43	50	Approved
63. Building New Beds in the Proposed Medical Center (Blain of Wayne)	43	50	Disapproved and referred to the Wayne County Medical Society for study
64. Composition of AMA Council on Medical Education and Hospitals (Ferguson of Kent)	43	50	Approved
65. Honorarium for Officers (Ryan of Kalamazoo)	43	46	Amended to refer to House of Delegates Study Committee
66. Reporting of Venereal Disease (Reference Committee on Hygiene and Public Health)	44	50	Approved
67. Special Commendation to Wilfrid Haughey, M.D., Battle Creek (Wemmer of Calhoun)	54	(not referred)	Approved
68. Oppose Passage of SB 3318 (Coast and geodetic medical care) and Similar Legislation (Levant of Wayne)	54	60	Approved
69. Owner and Licensure of Pharmacies (Rice of Jackson)	60	(not referred)	Approved

		Introduction of Business	*Reference Committee Report*	*Action*
XI.	*Awards*	29		
	(A) Report of Committee on "Certificates of Commendation"	29	51	
	(1) Supplemental Report of Committee on "Certificates of Commendation"	29	51	
	(B) Fifty-Year Awards	29		
	(C) Awarding of "Certificates of Commendation"	54		
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	(E) Special Memberships	50		
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	(a) Committee to Study Association Between MSMS and Michigan Medical Service	41	53	Amended in Recommendation No. 2 and approved
	(1) Supplemental Report of Committee to Study Association Between MSMS and Michigan Medical Service	41	53	Amended in Recommendation No. 2 and approved
	(b) Standing Committee on Constitution and Bylaws	41	43	Approved
	(1) Supplemental Report of Standing Committee on Constitution and Bylaws	41	43	Approved
	(c) Committee to Study Problem of Indigent or Ill Physician	41	50	Approved with recommendation for permanent Council Committee
	(d) Committee to Study Relationship Between Doctors of Medicine and Osteopaths	41	45 (2 items)	Amended and accepted
	(e) Committee on Relative Value	41	51	
XIII.	*Reports of MSMS Standing Committees*	41		
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	(4) Tuberculosis Control	41		
	(5) Cancer Control	41	48	
	(6) Occupational Medicine	41	48	
	(7) Mental Health	41	48	
	(8) Child Welfare	41		
	(9) Geriatrics	41	48	
	(10) Blood Banks	41		
	(11) Highway Accident Prevention	41	48	
	(12) Diabetes Control	41		
	(13) Iodized Salt	41		
	(c) Public Relations	41	49	
	(d) Ethics	41		
	(e) Legal Affairs	41		
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	(g) Advisory to Woman's Auxiliary	41		
	(h) Advisory to Michigan State Medical Assistants Society	41		
	(i) Professional Insurance Plans	41		
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	(b) Annual and Supplemental Reports of Standing Committee on Constitution and Bylaws		43	
	(c) Supplemental Annual Report of The Council No. 2 and Resolution Nos. 22 and 24		43	
	(d) Resolution No. 3		43	
	(e) Resolution No. 9		44	
	(f) Resolution No. 13		44	
	(g) Resolution No. 15		44	

	Introduction of Business	*Reference Committee Report*	*Action*
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3. *On Legislation and Public Relations*		57	
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		Introduction of Business	*Reference Committee Report*	*Action*
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10.	*On Resolutions (and Supplemental Report)* (a) Report of Committee to Study Problem of Indigent or Ill Physician (49); (b) Resolution No. 2 (49); (c) Resolution No. 6 (49); (d) Resolution No. 8 (49); (e) Resolution No. 18 (49); (f) Resolution No. 21 (49); (g) Resolution No. 31 (49); (h) Resolution No. 39 (49); (i) Resolution No. 41 (50); (j) Resolution No. 48 (50); (k) Resolution No. 57 (50); (l) Resolution No. 62 (50); (m) Resolution No. 63 (50); (n) Resolution No. 64 (50); (o) Resolution No. 66 (50)		49 & 50	
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Michigan State Medical Society

Ninety-seventh Annual Session, September 23-25, 1962

DIGEST OF PROCEEDINGS OF THE 1962 HOUSE OF DELEGATES

SUNDAY EVENING SESSION

September 23, 1962

The first session of the House of Delegates of the Michigan State Medical Society, held at the Sheraton-Cadillac Hotel, Detroit, Michigan, convened at 8 p.m., H. F. Falls, M.D., Vice Speaker, presiding.

I. RECORD OF ATTENDANCE

	1st	*2nd*	*3rd*	*4th*	*5th*
J. J. Lightbody, M.D., Speaker	x	x	x	x	x
H. F. Falls, M.D., Vice Speaker	x	x	x	x	x
D. Bruce Wiley, M.D., Secretary	x	x	x	x	x
K. H. Johnson, M.D., Immediate Past President	x	x	–	x	x
A. V. Wenger, M.D., Honorary Member	–	–			

DELEGATES

ALLEGAN					
Lewis F. Brown, M.D.	x	x	x	x	x
ALPENA-ALCONA-PRESQUE ISLE					
John W. Bunting, M.D.	x	x	x	x	x
BARRY					
Alexander B. Gwinn, M.D.	x	x	x	x	x
BAY-ARENAC-IOSCO					
David A. Bowman, M.D.	x	x	x	x	–
William G. Gamble, Jr., M.D.	x	x	x	x	x
BERRIEN					
Paul O. Rague, M.D.	x	x	x	x	x
Noel J. Hershey, M.D.	x	x	x	x	x
BRANCH					
Robert M. Leitch, M.D.	x	x	x	x	x
CALHOUN					
C. J. Ryan, M.D.	x	x	x	–	–
Keith S. Wemmer, M.D.	x	x	x	x	x
CASS					
Uriah M. Adams, M.D.	x	x	x	x	x
CHIPPEWA-MACKINAC					
Donald D. Finlayson, M.D.	x	x	x	x	x
CLINTON					
Franklin W. Smith, M.D.	x	x	x	x	x
DELTA-SCHOOLCRAFT					
Francis C. Anderson, M.D.	–	x	x	x	x
DICKINSON-IRON					
Donald T. Anderson, M.D.	x	x	x		
and E. Theodore Palm, M.D.				x	x
EATON					
Byron P. Brown, M.D.	x	x	x	x	x
GENESEE					
Clifford W. Colwell, M.D.	x	x	x	x	x
J. Leonidas Leach, M.D.	x	x	–		x
Lawrence G. Bateman, M.D.	x	x	x	x	x
Phillip K. Stevens, M.D.	x	x	x	x	x
H. Maxwell Golden, M.D.	x	x	x	x	x
William F. Buchanan, M.D.	x	x	x	x	x
GOGEBIC					
John R. Franck, M.D.	x	x	x	x	x
GRAND TRAVERSE-LEELANAU-BENZIE					
Frank H. Power, M.D.	x	x	x	x	x
GRATIOT-ISABELLA-CLARE					
Donald K. Barstow, M.D.	x	x	x	x	x
HILLSDALE					
Luther W. Day, M.D.	x	x	x	x	x
HOUGHTON-BARAGA-KEWEENAW					
Andrew M. Roche, M.D.	x	x	x	x	x
HURON					
Charles S. Elliott, M.D.	x	x	x	x	–
INGHAM					
John M. Wellman, M.D.	x	x	x	x	x
Robert M. Stow, M.D.	x	x	x	x	x
Herbert W. Harris, M.D.	x	x	x	x	x
Mahlon S. Sharp, M.D.	–	x	x	x	x
Lawrence A. Drolett, M.D.	x	x	x	x	x
IONIA-MONTCALM					
Robert E. Rice, M.D.	x	x	x	x	x
JACKSON					
John W. Rice, M.D.	x	x	x	x	x
Ross V. Taylor, M.D.	x	x	x	x	x
KALAMAZOO					
Frederick C. Ryan, M.D.	x	x	x	x	x
Donald G. May, M.D.	x	x	x	x	x
W. Kaye Locklin, M.D.	x	x	–	x	x
Don Marshall, M.D.	x	x	x	x	x
KENT					
J. Russell Brink, M.D.	x	x	x	x	x
Frederick C. Brace, M.D.	x	x	x	x	x
Noyes L. Avery, Jr., M.D.	x	x	x	x	x
Allison R. Vanden Berg, M.D.	x	x	x	x	x
James A. Ferguson, M.D.	x	x	x	x	x
John R. Pedden, M.D.	x	x	x	x	–
W. Clarence Beets, M.D.	x	x	x	x	x
Leo J. Kenney, M.D.	x	x	x	x	–
and Harvey M. Andre, M.D.					x
LAPEER					
James R. Doty, M.D.	–	x	–	x	–
LENAWEE					
Donato F. Sarapo, M.D.	x	x	x	x	x
LIVINGSTON					
Edwin S. Woodworth, M.D.	x	x	x	x	x
LUCE	not represented				
MACOMB					
Edward G. Siegfried, M.D.	x	x	x	x	x
Sydney Scher, M.D.	x	x	–	–	x
MANISTEE					
Robert R. Garneau, M.D.	x	x	x	x	–
MARQUETTE-ALGER					
Eugene R. Elzinga, M.D.	x	x	x	x	x
MASON					
Herbert G. Bacon, M.D.	x	x	x	x	x
MECOSTA-OSCEOLA-LAKE					
Paul Ivkovich, M.D.	x	x	x	x	x
MENOMINEE					
Herman R. Brukardt, M.D.	x	x	x	x	x
MIDLAND					
Harold L. Gordon, M.D.	x	x	x	x	x
MONROE					
S. Newton Kelso, Jr., M.D.	x	x	x	x	x
MUSKEGON					
Robert J. Fles, M.D.	x	x	x	x	x
H. Clay Tellman, M.D.	x	x	x	x	x
NEWAYGO					
J. Paul Klein, M.D.	x	x	x	x	x
NORTH CENTRAL					
Louis F. Hayes, M.D.	x	x	x	x	x
NORTHERN MICHIGAN					
Gerald Drake, M.D.	x	x	x	x	x

	1st	2nd	3rd	4th	5th
OAKLAND					
Robert M. Bookmyer, M.D.	x	–	x	x	x
Harold A. Furlong, M.D.	x	x	x	x	–
and Charles P. Barker, M.D.	–	–	–	–	x
Edward E. Elder, Jr., M.D.	x	x	x	x	x
Harry E. Lichtwardt, M.D.	x	x	x	x	x
Merle A. Haanes, M.D.	x	x	x	x	x
Paul T. Lahti, M.D.	x	x	x	x	x
Vincent P. Russell, M.D.	–	x	x	–	–
and Richard R. Galpin, M.D.	–	–	–	x	x
James R. Quinn	x	x	x	x	x
OCEANA					
Clarence E. Diehl, Jr., M.D.	x	x	x	x	x
ONTONAGON					
James P. Strong, M.D.	x	x	x	x	–
OTTAWA					
John H. Kitchell, M.D.	x	x	x	x	x
SAGINAW					
Robert F. Powers, M.D.	x	x	x	x	–
A. Carl Stander, M.D.	x	x	x	x	x
Vernon V. Bass, M.D.	x	x	x	x	x
ST. CLAIR					
William J. Dinnen, M.D.	x	x	x	x	x
James H. Tisdel, M.D.	x	x	x	x	x
ST. JOSEPH					
Charles W. O'Dell, M.D.	x	x	x	–	x
SANILAC					
Keate T. McGunegle, M.D.	x	x	x	x	x
SHIAWASSEE					
Claude L. Weston, M.D.	x	x	x	x	x
TUSCOLA					
Lloyd L. Savage, M.D.	x	x	x	x	x
VAN BUREN					
Thomas J. Dillon, M.D.	x	–	–	–	x
WASHTENAW					
Clarence E. Crook, M.D.	x	x	x	–	–
and Stuart M. Gould, M.D.	–	–	–	–	x
Henry A. Scovill, M.D.	x	x	x	x	x
L. Dell Henry, M.D.	x	x	x	x	x
Charles J. Tupper, M.D.	x	x	x	x	–
and George W. Morley, M.D.	–	–	–	–	x
Gerhard H. Bauer, M.D.	x	x	x	–	–
Dean P. Carron, M.D.	–	–	x	–	x
John M. Sheldon, M.D.	x	x	x	x	x
WAYNE					
Ralph R. Cooper, M.D.	x	x	x	x	x
Alfred H. Whittaker, M.D.	x	x	x	–	x
Robert K. Whiteley, M.D.	x	x	x	x	x
Don W. McLean, M.D.	x	x	x	x	x
James B. Blodgett, M.D.	x	x	x	x	x
David I. Sugar, M.D.	x	x	x	x	x
Milton R. Weed, M.D.	x	x	x	x	x
Sidney Adler, M.D.	x	x	–	–	–
Paul J. Connolly, M.D.	x	x	x	x	x
Albert D. Ruedemann, Sr., M.D.	x	x	x	x	–
James D. Fryfogle, M.D.	x	x	x	x	x
Wyman C. C. Cole, Jr., M.D.	x	x	x	x	x
Jack Rom, M.D.	x	x	x	x	x
William J. Yott, M.D.	x	x	x	x	x
Francis P. Rhoades, M.D.	x	x	x	x	x
Raphael Altman, M.D.	x	x	x	x	x
Homer A. Howes, M.D.	x	x	x	x	x
Alice E. Palmer, M.D.	x	x	x	x	x
George T. Bradley, M.D.	x	x	x	–	–
Alexander Blain, III, M.D.	x	x	x	x	x
John G. Slevin, M.D.	x	x	x	x	x
Edward J. Tallant, M.D.	x	x	x	x	x
A. Hazen Price, M.D.	x	x	x	x	x
Hugh W. Henderson, M.D.	x	x	–	x	x
Lawrence F. Segar, M.D.	x	x	x	x	x
G. Thomas McKean, M.D.	x	x	x	–	x
Charles E. Darling, M.D.	x	x	x	x	x
Louis Carbone, M.D.	x	x	x	x	x
Richard E. Wunsch, M.D.	x	x	x	x	x
Brock E. Brush, M.D.	x	x	x	–	–
Arthur B. Levant, M.D.	x	x	x	x	x
Edward M. Vardon, M.D.	x	x	x	x	x
Luther R. Leader, M.D.	x	–	–	–	–
Meyer O. Cantor, M.D.	x	x	x	x	x
Herbert W. Devine, M.D.	x	x	x	x	x
Floyd B. Levagood, M.D.	x	x	–	–	x
John R. Brown, M.D.	x	x	x	x	x
Louis J. Bailey, M.D.	x	x	x	x	x
Joseph Hickey, M.D.	x	x	x	x	x
Robert G. Swanson, M.D.	x	x	x	x	x
William L. Brosius, M.D.	x	x	x	x	x
A. Jackson Day, M.D.	x	x	x	x	x
Aaron Z. Rogers, M.D.	x	x	x	x	x
William M. Tuttle, M.D.	x	x	x	x	x
Charles J. France, M.D.	x	x	x	x	x
Howard C. Rees, M.D.	x	x	x	x	x
Max L. Lichter, M.D.	x	x	x	x	x
Joseph R. Montante, M.D.	x	x	x	x	x
Frank S. Perkin, M.D.	x	x	x	–	–
George S. Fisher, M.D.	x	x	x	x	x
Edward H. Lauppe, M.D	x	x	x	x	x
Clarence L. Candler, M.D.	x	x	x	x	x
WEXFORD-MISSAUKEE					
Gregory P. Moore, M.D.	x	x	x	x	x

MEDICAL STUDENTS

UNIVERSITY OF MICHIGAN					
Thomas H. Corbett	x	x	x	–	–
Gerhardt A. Hein	x	x	x	x	x
Robert C. Karlsberg	x	x	x	x	–
James J. Ryan	x	x	–	x	–
WAYNE STATE UNIVERSITY					
Walter Brewer	x	–	–	–	–
James Fenton	x	–	–	–	–

II. SPEAKER'S REMARKS

By J. J. Lightbody, M.D., Detroit

It is again a pleasure for me to welcome you to the annual meeting of the House of Delegates. Since we last met there have occurred a great many important events that affect the practice of medicine, particularly in the area of socio-economics. Many of these activities will be brought to your attention in the form of committee reports and in reports of the activities of The Council during the past year.

During the past year, the House of Delegates has had six committees appointed by the Speaker to study certain problems and to report to the House at this session. These committees of the House are:

1. Committee to Study Association between MSMS and Michigan Medical Service.
2. Standing Committee on Constitution and Bylaws.
3. Committee to Study Relationships Between Doctors of Medicine and Osteopaths.
4. Committee on Relative Value.
5. Committee to Study the Indigent or Ill Physician.
6. Committee on Certificates of Commendation, which replaces Michigan's Foremost Family Physician.

Ordinarily all of these six committee reports would be referred to reference committee, but the Committee on Certificates of Commendation is recommending to the House the names of four distinguished physicians of this State to receive awards. This Committee is to report to the House tomorrow morning; and if this report goes to a reference committee the House would not be able to act on it until tomorrow night or even Tuesday morning, which would not give us sufficient time to notify the recipients and have them plan to be present at a subsequent meeting to receive the awards.

I am going to suggest to the House at the meeting tomorrow morning that the House of Delegates act as a reference committee or committee of the whole to consider that portion of the report having to do with nominations for the awards, and the remaining portion will be referred to a reference committee in the usual manner. If the House agrees to this parliamentary procedure we will then be able to contact the recipients of the awards by Monday noon so that they may be present at a subsequent meeting of the House on Tuesday morning or Tuesday evening.

The 1961 House of Delegates authorized a poll on Social Security for physicians, and this was conducted and completed; the results of the poll were given to the Michigan delegates to the American Medical Association. The questionnaire which was sent to all members of the MSMS was developed by a consultant from Michigan State University, and the questionnaire was presented to

The Council for approval before being mailed to the membership. From a total membership of 6,775 members, usable returns were received from 5,520, or 81.5 per cent, which is a remarkably high return on this type of questionnaire.

Although many physicians have stated informally that they were in favor of inclusion of physicians in Social Security, when it comes to an actual vote it seems that the majority still do not want to participate. This was proven at the June meeting of the AMA House of Delegates, where the House reaffirmed its previous stand against Social Security for physicians.

At the 1960 session of this House of Delegates the term of Councilors was changed from five to three years, but apparently it was not fully appreciated that this change would bring up a rather unique situation in the year 1963. Next year, 1963, there will be nine Councilors whose terms expire and seven Councilors whose terms expire in 1964. There are a total of nineteen Councilors, and theoretically the membership of The Council could be almost completely changed with the election of nine new members. A plan whereby a temporary reapportionment can be accomplished has been referred to the Committee on Constitution and Bylaws, which will report to the House tomorrow morning.

The general meeting of the Society will be held as the first order of business on Tuesday evening at 8 p.m., at which time Dr. C. I. Owen, of Wayne, will be formally inducted as President of the Michigan State Medical Society. I bring this occasion to your attention so that you may make every effort to get as many members and friends to attend this really important function of the House and give our new President the royal and dignified welcome which a President richly deserves.

This House now has fourteen reference committees, and the first of these committee meetings will probably be held tomorrow afternoon unless we finish our agenda early tomorrow morning. Resolutions referred to these committees will be presented to the House tomorrow morning and will be presented in numerical sequence. Only the "resolved" portion of the resolutions will be read to the House by the member presenting the resolution.

If any delegate has a new resolution which he plans to present and which has not already been mimeographed, it must be made up in triplicate in the usual manner, and at the time of introduction of the resolution it must be read *in toto,* not just the "resolved" portion.

The resolutions will be found in your notebook grouped together in consecutive order rather than separated in the respective reference committee section.

Your Speaker and Vice Speaker greatly appreciate the past courtesy and cooperation of the House, and we will do our best to conduct your meetings with proper consideration to majority opinion and minority rights consistent with expediting the important business of this House. [*Applause*]

The Vice Speaker: Speaker Lightbody's report will be referred to the Reference Committee on Reports of Officers.

III. PRESIDENT'S REMARKS

By Otto K. Engelke, M.D., Ann Arbor

It is great to be an active member of a winning team. Michigan doctors of medicine, their county and district medical societies, the Michigan State Medical Society and the American Medical Association are such a team.

With the expert help of the dedicated laymen on the staffs of our several societies and with the support of thinking people everywhere, we have won another major victory in our never-ending struggle to preserve our unexcelled American system of medical care. Our defeat of King-Anderson type legislation this year has been especially important.

We should have renewed confidence in ourselves and in our public image as practitioners of medicine and in our organizations as the representatives and spokesmen for medicine. The American people are now alerted to the fight we have been waging against the forces of imported socialism. The majority are on our side. They know of our desire to continue our efforts to better serve them by meeting our responsibilities and developing our opportunities in a traditionally American way.

The people know that this is a nation which has in a large measure controlled or stamped out many of our most dangerous and communicable diseases; that we have eliminated major dangers of child bearing; that we have conquered the ravages of malnutrition. They also know that giant strides have been taken to protect us all from important hazards in the environment and that these efforts are, of course, frequently interrelated.

Although time does not permit reporting the countless other examples of similar successes throughout the medical care and health field, our public is informed about them. They know, too, that research programs currently under way promise equally dramatic results in areas where major progress still remains to be made.

They have been convinced that all this has been made possible primarily by our medical care and related health system as we now know it.

The public generally is asking questions and reviewing allegations and is coming up with answers that are in substantial agreement with ours, such as: "What can be so wrong with a medical health program which has played a key role in prolonging the lives of people to the point where to some this has become a problem—a delightful dilemma, as it were?" Or, "Isn't it interesting that American medicine, which has been so important in protecting this effective medical care system, should be criticized because it does not embrace every crackpot idea for change?"

Cliches like "American medicine is always against everything and never for anything"—words reformers have used so often that some of us find ourselves repeating them—and "American medicine should have a positive program," no longer disturb the thinking citizen.

The American people and we in American medicine were not born yesterday; nevertheless, our opponents have tried to confuse and defeat us with one of the oldest debating tricks in the business. Under this scheme, those who are unhappy with things as they are propose an impossible "plan" for the solution of alleged problems. When this ridiculous plan is attacked with reason and logic, a challenge is issued for the production of another new and better plan. The trick, then, is to spend all available time arguing about which of the two should be applied, when in fact the matter of whether or not either one was necessary in the first place is extremely debatable.

The best medical care-health program the world has ever seen—the one we have now—is the positive plan of American medicine. It includes a full development of voluntary medical care and hospital insurance led by Blue Shield and Blue Cross. It also calls for a prompt state-by-state adaptation of the useful provisions of the Kerr-Mills Act in meeting the needs of the medically indigent.

It recognizes the virtues of flexible solutions for problems which vary by areas. It searches for improvements in local, state and federal laws which have been working so well for so many years in the care of those who need help. It would be folly for us to try to devise another untried "new" plan.

Another reason the King-Anderson defeat this year was especially productive is that our struggle and our victory have awakened members of many key groups to their peril. Important people in the farm organizations, the legal, the dental, and other professions as well as the Chambers of Commerce, associations of retired workers, in addition to many others, have recognized in King-Anderson a general movement toward the nationalization or socialization of American enterprise and resources.

They do not like the prospect any more than we do. We have won many powerful new allies and strengthened our relationships with old ones.

The major decision on medical care was made in the national Congress this year by elected representatives of the people. This decision, which was in our favor, was extremely close. Decision-making by elected representatives and others in government will be more and more important as time goes on. This will be true next year. This will be true from here on in, at all levels of government.

Our well-informed public and our newly won allies expect us to actively support candidates for all public offices and elected officials who share our beliefs and vote accordingly. If we are to consolidate our gains and achieve a final and lasting victory, this support must be quickly given, vigorous, liberal and tangible.

If we ever doubted it, we must know now that a good doctor, whether in research, in teaching or in practice, is one who works with his society and with others to support candidates for public office and current public office-holders who share our philosophies.

This past year's successes at the state and national levels have reassured us about something we have known all along. When the chips are down our membership, the Auxiliary and our allied groups produce the grass-roots support that wins. They all deserve our highest compliments. We must remind them, however, that their good work should be intensified. We must win our fight in Michigan and in America this November and ever after. If we lose there is no other place to go.

This coming year we will receive stimulating leadership from my successor and good friend, Dr. Clarence I. Owen. He has my best wishes and pledge of full cooperation. The officers, committee members and other medical associates in MSMS are an inspiring group. Our workers on the MSMS paid staff are unbelievably skillful, tactful and productive.

Working for this great Society has been a thrilling privilege. My thanks to each and every one of you for your help.

The Speaker: Dr. Engelke's remarks will be referred to the Reference Committee on Officers' Reports.

IV. PRESIDENT-ELECT'S REMARKS

By C. I. Owen, M.D., Detroit

On the eve of my assumption of the office to which you elected me last September in Grand Rapids, may I express my appreciation for your confidence, and my promise to carry on the responsibilities of this great office to the best of my ability.

With your help—and only with your generous help—will the work of the Presidency during the ensuing year enhance the continuing success of your State Society. I therefore beg and expect your advice, your guidance and your assistance so that what we do in the next twelve months will redound to the greater prestige and position of the Michigan State Medical Society.

Today, I have but six short points to invite to your attention. Their importance is not to be confused with the brevity of my presentation nor the order in which they are presented.

1. *Hospital Licensing Bill.*—I would like to mention the hospital licensing bill which undoubtedly will be presented again to the Michigan Legislature at the next Session. The 1962 Legislature, in postponing action on hospital licensing, virtually ordered all interested parties to get together and work out something mutually satisfactory before January of 1963.

Your Legislative Committee is charged with working with other interested groups. However, a bill must be produced that will be satisfactory to the Michigan State Medical Society. Since the subject matter of this proposal is vital to several groups, no one organization should make the error of proposing a measure containing only its own elements of interest. That would be contrary to the desires of the Legislature. Your assistance to the Michigan State Medical Society Legislative Committee in the development of a good hospital licensing bill is urged.

2. *Governor's Commission on Prepaid Hospital and Medical Care Plans.*—The recent report of the Governor's Commission on Prepaid Hospital and Medical Care Plans, based on the McNerney Study, was presented to the Governor early this summer. I presume that this report, or at least its forty-five recommendations, have been read and studied by all of you.

While, in the main, the Commission's report was favorable to the work of Blue Cross and Blue Shield, and it admitted throughout that the medical practitioners in Michigan are doing a good job, nevertheless some of the recommendations are ominous with plans of centralization or federalization.

This report is not likely to gather dust on the present Governor's shelf; its pages will be rustled into action and its recommendations will become prophetic commandments for early implementation.

Fortunately, our Society has an excellent Committee, headed by our Vice Speaker, Dr. Harold F. Falls of Ann Arbor, which has alerted us to the dangers to medical practice inherent in the report. This Committee's determinations are backed up by facts and figures developed by the new Medical Socio-Economic Department which you created last September.

May I urgently recommend that all members of this House of Delegates know and understand the implications inimical to medical practice in the Governor's Study Commission Report, and that every member follow the leadership of your State Society in vigorously opposing any programs that will dilute or interfere in any way with the present high quality of medical care in Michigan. As elected leaders in your counties, you delegates have the opportunity—yes, the sacred obligation—to alert your constituents to the impact this report may have on their individual medical practice.

3. *The Osteopathic Question.*—Since the American Medical Association House of Delegates referred the question of M.D. association with osteopaths to the individual states, the present situation among the fifty states is as varied as Joseph's coat of many colors. Your Michigan State Medical Society House of Delegates Committee, headed by Dr. John G. Slevin of Detroit, will soon report to you concerning its deliberation and recommendations.

Another committee of The Council, headed by Dr. J. J. Coury, of Port Huron, is currently arranging meetings with the osteopathic leaders of the State to investigate areas of cooperation.

Let me stress that whatever is decided on the osteopathic question (and it may take months if not years to come to a sane solution), the final agreement must be completely satisfactory to the county society. For the benefit of the patient, areas of mutual understanding must be developed; but in the last analysis the county society must be the final arbitrator in any and all decisions.

4. *Relative Value Scale.*—At this session of the House of Delegates you undoubtedly will discuss whether you will or will not approve a relative value scale for Michigan. At the present time a scale imported in part from California is being used. My own opinion is that Michigan should have its own relative value scale, adapted to Michigan's own problems.

The Michigan relative value scale should meet the needs of surgeons, the requirements of internists, and properly fit the scope of all generalists and other specialists in our State. To adopt our own Michigan relative value scale will be another step in the progress of the Michigan State Medical Society because it will be a

distinct service to each and every one of our individual members.

5. *Headquarters Organization.*—The Council is submitting to you, as its Supplemental Report No. 2, a recommendation to reorganize the headquarters staff so that the Bylaws of the Michigan State Medical Society agree with a factual situation that has been in existence for many years. This report is the result of long study and deliberation by an ad hoc committee. The duties of the Secretary are spelled out in the Bylaws in great detail, listing many clerical duties and minutia, and functions that formerly had to be carried out personally by the Secretary before the Michigan State Medical Society had an executive office staff.

They gradually have been assigned to the full-time Executive Director and his staff. This change will bring our Bylaws up-to-date and will provide a working arrangement needed for certain changes that will take place in the not-too-far-distant future incident to the retirement of our present Executive Secretary. I sincerely recommend your favorable consideration of this change in the Bylaws in order to meet the changing time.

6. *Michigan Foundation for Medical and Health Education, Incorporated.*—This organization, sponsored by the Michigan State Medical Society, is doing a magnificent job in a prescribed area under the Presidency of E. I. Carr, M.D., of Lansing. Much commendation is due to Dr. Carr and all members of the Foundation Board for their vision and for their aid to medical education through loans to medical students, and for public information in the health field.

However, little is known of their work. Even some of our own members are not aware of what is going on. In addition, new problems have arisen which need solution and which well could be funneled to this Foundation.

Two such problems came up before the House of Delegates last year, and there are committees which will be reporting to you on these matters. One is the problem of indigent or ill physicians, and the second is the question of a loan fund for new physicians. I would urge that you recommend to the Michigan Foundation for Medical and Health Education that it enlarge its membership to include more doctors widely distributed throughout the State.

Another recommendation to the Foundation which I urge is that it broaden its functions to include charitable activities, such as aid to the indigent or ill physician, and perhaps the granting of loans to new physicians. By such minor changes greater interest would be created, and it would be easier for the Foundation to raise money.

May I close this message to you, my good friends, the members of the 1962 House of Delegates, by wishing you a successful convention. I personally shall miss participation in active debate on the floor of the House and before the reference committees. Let us continue, as in the past, to set medical standards and policies for the good of all of the people in our State and for the maintenance of a sound system of medical practice.

The Speaker: Dr. Owen's remarks will be referred to the Reference Committee on Officers' Reports.

IX. REPORTS OF THE COUNCIL

IX—A. ANNUAL REPORT

O. B. McGillicuddy, M.D., Lansing, Chairman of The Council:

The Annual Report of The Council is printed in your Handbook.

IX—B. SUPPLEMENTAL ANNUAL REPORT OF THE COUNCIL

Membership

On September 1, 1962, the membership of MSMS totalled 6,892 as compared with the total of 6,755 at the same time last year. A breakdown of the current total shows the following:

Active	5,958
Life	396
Associate	379
Retired	112
Military	39
Non-resident	2
Honorary	6
Total	6,892

Finances

December 1, 1961 through August 31, 1962

ACCOUNT	Income to 9/1/62	Expenses to 9/1/62	Balance at 9/1/62
General Fund	$219,716.89	$180,539.61	$39,177.28
Annual Session	27,135.00	7,187.73	19,947.27
Michigan Clinical Institute	13,160.00	17,803.72	4,643.72 CR
The Journal	91,179.42	80,943.53	10,235.89
Public Education	46,861.31	37,540.47	9,320.84
Department of Economics	29,288.00	16,130.87	13,157.13
Professional Relations & Public Service	41,003.31	22,452.63	18,550.68
Rheumatic Fever	———	3,323.32	3,323.32 CR
Headquarters Maintenance & Debt Retirement	87,864.61	83,022.33	4,842.28
House of Delegates	17,572.84	12,701.21	4,871.63
Contingency Fund	7,026.30	———	7,026.30
	$580,807.68	$461,645.42	$119,162.26
Less: Notes on Hdqts. Construction Paid from Current Income, 1962			100,000.00
Balance:			$ 19,162.26

At this time I beg permission of the House of Delegates to call upon the Chairman of our Finance Committee, Doctor Warren Babcock, to give you in capsule form exactly what these accounts and figures represent, the amount of money we have on hand, where it is, and what we have to do with it.

Headquarters Financing

The construction, furnishing and landscaping of the MSMS Headquarters Building was financed by (1) the liquidation of most of the MSMS investments, (2) sale of the previous headquarters building on Townsend Street and (3) by borrowing from the Michigan National Bank in the form of unsecured notes. During the period of construction, the current MSMS income was used to pay much of the construction expense, to limit borrowing.

At no time has the amount of borrowed funds exceeded $250,000. The MSMS policy has been to repay as many of the notes as possible during the early months of each year, when dues income is high, and to reborrow only those funds needed for current Society expenses later in the year when income is low. This method has resulted in interest savings of approximately $4,000.00 per year. No mortgage ever had to be placed on the headquarters building.

The total of borrowed funds is being reduced from income on the basis of $50,000 per year. As of September 1, 1962, the amount of debt was $100,000. However, it will be necessary to borrow additional funds to cover current Society operations between now and February 1, 1963. It may be necessary to increase the loan to $200,000. The loan will be reduced in 1963 as dues income is received.

Suggestions re Ways and Means Reference Committee

The Finance Committee of The Council and the Speaker of the House of Delegates have discussed means of providing information to the Delegates regarding costs and availability of funds in connection with proposed projects being considered by the Delegates during their deliberations.

Since the House of Delegates has an established mechanism for just this purpose in its Ways and Means Reference Committee, the Speaker and The Council sug-

gest that this Reference Committee might work to greater advantage of the Delegates and the Society if any resolution involving an expenditure of MSMS funds were referred to a Reference Committee appropriate to the subject matter, and simultaneously to the Ways and Means Reference Committee for advice only on cost and availability of funds.

Organization

A conference was held in every Councilor District during the past two months, to transmit the latest information on Michigan State Medical Society activities to Delegates, Alternate Delegates, and Component Society Officials. A chart of these meetings indicating dates and places is part of the addenda to this report.

County Society Bylaws

Legal Counsel Lester P. Dodd has on frequent occasions invited to the attention of The Council problems arising from the failure of component societies to keep their bylaws consistent with those of the State Society. These problems arise most frequently in relation to grievance and disciplinary procedures and in relation to membership classifications. Section 1 of Chapter 1 of the Bylaws of MSMS provides that the charter of each component county society "shall require that the constitution and bylaws of such component county society be at all times consistent with the provisions of the constitution and bylaws of this society and with all amendments thereto hereafter adopted."

The Council is advised that serious legal consequences may result from the failure, on the part of county societies, to bring their bylaws into line with those of the State Society and to follow the procedures that are there required. (Recommendation No. 8 on this subject follows.)

MSMS Group Insurance Programs

1. MSMS Group Term Life Insurance Program as of September 1, 1962. The report for the past 12 months was as follows:

Number of members now insured	1,425
Amount of insurance in force	$12,600,000
Premiums collected during past year	$104,650
Claims paid during past year	$66,500
Claims now pending	$3,500

2. MSMS Group Health and Accident Plan.

Currently there are 2,073 members enrolled in the Plan. This is a net gain of approximately 50 over the number insured at this time a year ago. Constant effort is being made to maintain and increase participation in the Plan.

During the past twelve months 472 payments were made to 222 doctors. Thus an average of better than one in ten enrolled members had occasion to call upon the insurance and to receive benefits during the year.

The payments came out to an average of 39 per month, or approximately 2 each working day.

The over-all loss picture remains satisfactory, and the plan of increasing by 10 per cent all claim payments due to disability because of favorable experience (inaugurated November 15, 1959) will be continued throughout the policy year beginning November 15, 1962.

During the past twelve months, one claim was paid for accidental death.

Obtaining McNerney Report

DR. MCGILLICUDDY:

Copies of the McNerney Report: The American Hospital Association has just informed MSMS that the two-volume report will be available October 15, 1962. The pre-publication price is $17.50. Subsequently, the price will be $20.00 for the two volumes.

Teaching and Research Efforts re Alcoholism

The Committee on Alcoholism and Narcotics Addiction, at its May 17 meeting, requested The Council to include in its Annual Report to the 1962 House of Delegates a recommendation "that the Michigan medical schools be encouraged to increase their teaching and research efforts re alcoholism because of the importance of the problem." The minutes of this meeting were approved by The Council.

(Recommendation No. 9 on this subject follows.)

* * *

Several committee reports in the Supplemental Report of The Council are from committees appointed at the direction of the House of Delegates. The Council has received these reports but has taken no action on them, believing that they should be considered by the House of Delegates.

IX—B (1) ANNUAL AND SUPPLEMENTAL REPORTS OF COMMITTEE ON MEDICAL SOCIO-ECONOMICS

By H. F. Falls, M.D., Ann Arbor, Chairman

It is a pleasure to report on the accomplishments and activities of your new Department of Socio-Economics. Published in your Handbook, under Reports of Standing Committees, is the annual report of the Committee on Medical Socio-Economics. This report adequately outlines the origin of this MSMS Department of Socio-Economics, describes its faculty, and emphasizes its philosophy.

My Committee is both proud and pleased with the manner and efficiency with which Mr. Richard Campau and Professor C. T. Hardwick created, equipped and staffed the new Department.

Among the major assignments immediately delegated to this Department was the preparation of material and testimony for MSMS's presentation to the Governor's Commission concerning Prepaid Hospital and Medical Care Plans (the McNerney Report). Your Society's officers will attest to the value of Mr. Campau's and Professor Hardwick's valuable aid and counsel.

As Consultant to the Governor's Commission representing MSMS, I personally can attest to the invaluable services of the Department particularly in respect to furnishing and providing the following:

1. Resource information.
2. Compilation of MSMS principles and philosophy concerning immediate matters under discussion.
3. Counsel and direction pertinent to interpretation of ideals and philosophies of other interested groups and specific personnel.

Component county medical societies and specialty groups have been invited to organize socio-economic committees. Twenty-one such committees are in existence today. It is anticipated that these committees will serve at times as subcommittees of the MSMS Socio-Economic Committee and function as follows:

1. To evolve and study their particular and specific socio-economic problems.
2. To aid the MSMS Socio-Economic Committee in State and local research projects.
3. To make recommendations and suggestions as to the direction and scope of the MSMS Committee's research.
4. To use the MSMS Committee as a sounding board upon which to express philosophy, furnish, and in turn secure information and specifically gain the ear of organized medicine in the State.

Additional activities of the Department and of this Committee have been detailed in the report to you contained in the Handbook. Of necessity, and specifically because of the emergency nature of this year's assignments, most of the work has concerned short-term research to gain factual information needed as background

material for use of your officers and staff personnel to answer immediate legislative and economic problems.

It is hoped that in the coming year the Department will be free to initiate long-term and extensive research into the socio-economic problems which will confront MSMS tomorrow and in the future. Among those that have been suggested are:

A—A complete survey of the world medical economic situation with reference to the cost of medical care in other countries and particularly the quality and quantity of medical care provided.

B—Organized medicine's interpretation of:

1. The proper role of government in the providing of medical care.
2. The proper role of the hospital in the providing of medical care.
3. The proper role of the private practitioner in the providing of medical care.
4. The proper role of the medical schools in the providing of medical care.
5. The proper role of group practice in the providing of medical care.
6. The proper role of ancillary personnel in providing medical care.

C—Lastly, and probably most important, an attempt should be made to spell out for all M.D.s (the practitioners, the teachers, the salaried, et cetera) just what constitutes organized medicine's (1) principles, (2) goals, (3) standards, (4) philosophy, and (5) need for unification.

D—Each of the MSMS membership—specifically you —is invited to submit ideas to this Department. Your Committee of Socio-Economics accepts the challenge of these long-term goals with greater courage tonight than they did one year ago.

MSMS's new Department is dedicated to serving medicine, and with this team on our side I prophesy that some of the needed answers will soon be forthcoming.

My Committee wishes to thank the personnel of the Socio-Economic Department and the staff of MSMS for the splendid job performed in the past year, and to specifically commend them for their dedication to medicine's problems.

The Medical Socio-Economic staff and I will be available to your House of Delegates Reference Committee, where we will be more than willing to go into more detail about this important new Department.

The Speaker: That portion of The Council's report having to do with the report of the Medical Socio-Economic Committee will be referred to the Reference Committee on Special Committees.

ADDITIONAL ANNUAL REPORTS OF COMMITTEES OF THE COUNCIL

Committee on Awards

Awards were given in the 1961-1962 year in accordance with the practices and traditions of MSMS. Although this Committee was not responsible for the nomination of all those who received awards it has taken the responsibility of citing them in this report so that there will be, in one report a review of all awards given.

At the House of Delegates in September, 1961, Mr. John Reid, East Lansing, former Commissioner of Labor of Michigan and long time member of the Board of Directors of Michigan Medical Service, was elected to honorary membership. He was presented with a gold membership card on February 2, 1962, at the annual meeting of The Council.

At the same session the House of Delegates also recognized the outstanding services of H. J. Meier, M.D., Coldwater, retiring Chairman of The Council, and Kenneth H. Johnson, M.D., Lansing, retiring President. Appropriate awards were made to these distinguished medical citizens at the annual County Secretaries-Public Relations Seminar.

Traditionally, MSMS recognizes those members of the state society who have distinguished themselves as a result of the election to the presidency of national medical organizations. In keeping with this tradition, Traian Leucutia, M.D., Detroit, and Ross V. Taylor, M.D., Jackson, were recognized for their presidency of the American Roentgen Ray Society and the American Society of Internal Medicine, respectively.

These awards were also presented at the County Secretaries-Public Relations Seminar as well as an award to G. Thomas McKean, M.D., Detroit, for his devoted and outstanding service as president of Michigan Medical Service. Doctor McKean received the Distinguished Service Award.

On this same occasion, the Outstanding Health Service Award was given to three laymen who have made outstanding contributions to health. These were: Martin Fleming, Dearborn, for his long service as Chairman of the Michigan Crippled Children's Commission; Granger Weil, Port Huron, for his outstanding editorial support of medicine in his capacity as editor of the *Port Huron Times Herald,* and John W. Castellucci, Chicago, for his contributions as Executive Vice President of the Blue Shield Medical Care Plans and long service in behalf of voluntary prepaid medical care plans.

The Committee also takes note that the Michigan Foundation for Medical and Health Education honored George Crile, M.D., Cleveland, and the Michigan Cancer Coordinating Committee honored Owen H. Wangensteen, M.D. Both of these outstanding medical teachers were lecturers under the sponsorship of the respective organizations which honored them.

Twenty members of MSMS completed fifty years in the practice of medicine and were so recognized by election to the MSMS Fifty Year Club at the 1961 session of the House of Delegates and an approximately equal number will be presented for approval in the 1962 session.

The Committee recognizes the wisdom of the House of Delegates in changing the Michigan Foremost Family Physician Award to a recognition award for more than one physician and looks forward to its action in the selection of these designates in September.

Committtee on Hospital Relations

This Committee considered the problem presented by the Michigan Hospital Association regarding admission of osteopathic hospitals to membership in the Michigan Hospital Association. Note was taken that the Greater Detroit Area Hospital Council has admitted osteopathic hospitals to its roster.

However, in view of the fact that the Michigan State Medical Society set up a study committee to report on relationships with osteopaths to be reported at the next session of the House of Delegates, recommendation on this question was held in abeyance.

MHA reported its "Principles For Establishing Hospital Charges" as formulated. There is a desirability for closer relationship of hospital costs to charges. The consensus of this Committee was in favor of the objective of such principles.

A recent communication from MSMS Council charged this Committee with finding a sponsor to pay the costs of a survey of State and Government hospitals as passed at the last session of House of Delegates. However, no solution to this problem has been found as yet. Further exploration is indicated.

The MSMS Council has presented a definition of purposes of this Committee as follows:

1. To study rules and minimum standards for hospitals.
2. To study hospital constitutions and bylaws.

3. To study principles of physician and hospital relations.

4. Responsibilities of physicians and hospitals during disasters.

5. To combine medical and hospital interests so as to improve health care and maintain minimal hospital costs through cooperative effort.

Liaison Committee with Michigan State Board of Registration in Medicine

The date for the scheduled meeting of your Committee with the Michigan State Board of Registration in Medicine (June 14, 1962) conflicted with the dates of the Upper Peninsula Medical Society Session which a number of the members of your Committee were assigned to attend, so the joint meeting with the State Board was postponed. State Board Secretary E. C. Swanson, M.D., has promised to invite the MSMS Committee members to attend a future meeting of the Michigan State Board of Registration in Medicine to discuss matters of mutual interest.

Ad Hoc Committee for Providing Resource Material on Medical Matters to the Constitutional Convention

The ad hoc Committee for Providing Resource Material on Medical Matters to the Constitutional Convention had one formal meeting on November 30, 1961. Additional informal meetings were held from time to time during the tenure of the Constitutional Convention.

Recommendations were transmitted to the President of the Constitutional Convention and appropriate committee chairmen of that body. The proposed revised Michigan State Constitution contains no "health" references which are not appropriately constitutional and does not spell out in detail matters which properly require legislative enactments.

The proposed new Constitution provides: "The public health and general welfare of the people of the state are hereby declared to be matters of primary public concern. The legislature shall pass suitable laws for the protection and promotion of the public health." Also of interest is the following provision: "At no time shall an examining or licensing board of a profession include less than a majority of members of that profession." In regard to this provision, the Committee was not called upon for advice.

The proposed Constitution also provides that "All executive and administrative offices, agencies and instrumentalities of the executive branch of state government and their respective functions, powers and duties . . . shall be allocated by law among and within not more than 20 principal departments . . . grouped as far as practicable according to major purposes."

With the splendid cooperation of the Ingham County Medical Society, a well-equipped first aid facility was located at Convention Hall for the convenience of the delegates. The Constitutional Convention officially expressed its appreciation to the Ingham CMS and the Michigan State Medical Society by adoption of a resolution commending the medical profession for its thoughtful courtesy.

State Fair Committee

The State Fair Committee of the Michigan State Medical Society has had multiple meetings throughout the year, both as full committtee and as sub-committees. We have attempted to formulate two programs:

1. A simple exposition type demonstration for the 1962 State Fair.

2. Groundwork planning of a more elaborate Health Fair for the 1963 State Fair.

Members of the Committee have been faithful in attendance, diligent in their efforts and enthusiastic about the prospects of doing a good public health job for the Michigan State Medical Society in 1963. As Chairman, my personal thanks to them, to the representatives of the para-medical group personnel and to Ray Scott and the members of his staff.

Committee on Professional Insurance Plans

Recommendation: That the several proposed changes in the Group Life Insurance Plan of the Michigan State Medical Society be approved to bring it into closer alignment with the Wayne County Medical Society Group Life Insurance Plan; and that approval also be given to the proposal to offer all MSMS members additional low-cost life insurance.

The Committee met four times during the past year, January 18, 1962; February 1, 1962; March 8, 1962; and April 26, 1962. The Committee work can be divided into five areas:

1. Consideration of "one insurance plan" for MSMS and Wayne County Medical Society:

The Committee in its report to the 1961 House of Delegates stated that "the Committee will continue to pursue this matter if there is sufficient demand for such a plan." The Council during 1960-61 had referred such a request from the Wayne County Medical Society to this Committee for study. Members of the Wayne County Medical Society Insurance Committee met with the MSMS Committee January 18, 1962 and March 8, 1962 to explore a contention that such an arrangement might provide better coverage at a better price. Throughout the discussions with representatives of the two insurance firms involved it was stressed that whatever might be developed it would be imperative that all presently-covered doctors would remain covered without new physical examinations. The Committee at its April 26, 1962 meeting took action toward a more unified plan that would make four changes in the MSMS plan to make it identical to the Wayne County Medical Society coverage: (1) so the amount of life insurance would remain level at $10,000, (2) so the policy may be continued from age 70 at a higher premium, (3) to provide either term or a combination of term and permanent life insurance and (4) to provide for dependents coverage. The Committee also sought to offer all MSMS members additional low-cost life insurance.

Such changes have been developed cooperatively by the insurance carrier of the MSMS group insurance plans and by the insurance carrier of the Wayne County Medical Society. The Committee is available to explain the technical changes in coverage and premiums. The Committee recommends approval by the MSMS of these changes to improve the insurance coverage available to MSMS members.

2. Liaison with the Michigan Chapter of the Health Insurance Council:

Two committee meetings were held with leaders of the commercial insurance industry; one on August 22, 1961 which was not reported in the 1960-61 report of this Committee, and another on February 1, 1962. For several years now the MSMS insurance committee on leaders of the Michigan chapter of the Health Insurance Council have met to discuss common concerns. Discussion at the two meetings covered such matters as County Medical Society Committees to Review Insurance Questions. Use of the Jointly-Approved AMA-Insurance Industry "Comb. 1" Forms to Report Medical Care to Insurance Firms, and legislative matters of joint interest.

3. Follow-through of 1961 House of Delegates Resolution No. 39:

Resolution No. 39 seeks to encourage the insurance industry to promote the availability of paid-up-at-65 health insurance. A representative of the Health Insurance Association of America reported that such clauses can be added now to policies offered by some of the major health insurance firms. It was reported that the Health Insurance Council (National) in 1959 urged companies to develop such coverage and that more and more companies are doing so.

4. Possible Major Medical Insurance Coverage for MSMS Members and Families:

The 1961 MSMS House of Delegates adopted Resolution No. 45 which "authorizes The Council to make appropriate studies of supplemental insurance programs for MSMS Members." The Resolution pointed out that MSMS has provided a Group Health and Accident Insurance program since 1955 and a Group Life Insurance Program since 1959 and that "a number of members have requested MSMS to provide a Major Medical Insurance program which would provide added insurance protection for the MSMS member and his family."

The Committee held several conferences with representatives of the Michigan Medical Service to investigate the possible development by MMS of a special Master Medical Contract for MSMS members and their families. The many details have not been worked out at this time.

The Committee can report also that various commercial insurance companies have presented possible Major Medical Insurance Plans for consideration.

Resolution 45 re Major Medical Insurance Program. Your Committee on Professional Insurance Plans met four times and discussed the possible major medical insurance for MSMS members. Invited to Committee meetings were representatives of Blue Shield and of several commercial insurance companies. The Committee strongly supports the traditional principles of professional courtesy among MSMS members and has sought a plan for hospital coverage only. The delay in negotiations, in part, has been occasioned by this unique request of the Committee that hospitalization coverage only and not medical indemnity coverage be secured for MSMS members.

The Committee is in agreement that major medical hospital coverage be obtained through Michigan Medical Service, provided that their rates are favorable with those of commercial carriers. The Committtee respectfully requests permission of the 1962 House of Delegates to develop the details and to offer such coverage to MSMS members after approval is given by The MSMS Council.

5. Continuing Blue Cross-Blue Shield Coverage for Widows:

The Committee at its April 26, 1962 meeting received correspondence from The MSMS Council seeking information about the matter of continuing Blue Cross-Blue Shield coverage for widows of MSMS members. The matter was investigated and Blue Shield in a letter June 7, 1962 explained the procedure. Briefly it is as follows:

The widow of an MSMS member in the MSMS Group is offered a group conversion contract containing the same benefits as the group contract but at a rate that is 10 per cent higher than the group rate. Blue Shield, upon notification of the death of the M.D. subscriber, will automatically continue to offer group coverage and group rates for a 3-month period thereafter. Following this 3-month period of coverage, the group conversion contract is automatically offered to the widow. (The only time that a widow's coverage could lapse is when she both fails to make her payment for a regular billing occurring at or about the time of death of the member and she fails to notify Blue Shield of this event.)

IX—B (2) FINANCIAL REPORT

By W. W. Babcock, M.D., Detroit

The running of any state medical society is big business. It is up to the Finance Committee at the beginning of each year to estimate the probable income of the Society and to apportion that estimated income to the various departments in budget form. These apportionments vary from year to year, depending on directives from the House of Delegates and The Council, plus any unexpected emergencies that may arise. So, as you can imagine, our budget estimates are but intelligent guesstimates.

This year we were lucky, and most departments kept well within their budgets, with the exception of The Journal. Here we were off by a $20,000 figure due to an unexpected drop in estimated advertising revenue.

In developing the annual budget the Finance Committee is helped by Mr. Burns, Mr. Tryloff, by our Treasurer Dr. Hyland, and our auditor Robert Rooney, and the officers of The Council. Throughout the year it is up to the Finance Committee to study the monthly expenditures of the Society and to try and give the doctors of the State the best value possible for their dues.

On page 1 of the Supplemental Report of The Council, under the heading "Finances," and continuing on to page 2 of the same report, is a summation of income and expenses that is self-explanatory. You will note that the credit balance as of September 1 is $19,162.26. To me this is a small figure for a half-million-dollar business. It will mean that, because the dues are now paid for 1962, from now until the first of the year we will borrow from the bank until we receive our 1963 dues to operate the rest of the year. I am hopeful that we will not have to borrow more than $100,000. If we can keep within this limit we will reduce our total indebtedness to the bank by $50,000 in 1962. This will make our total 1963 indebtedness no more than $200,000.

The paragraph on the second page explains our method of our New Building Financing. By paying up the notes the first of the year, and reborrowing as necessary, we save on interest charges approximately $4,000 each year. At no time have our total loans exceeded $250,000.

The MSMS is deeply indebted to our Treasurer, Dr. William Hyland, for his arranging this system of taking care of our building notes. You can obviously see that such an arrangement is definitely to the benefit of MSMS and not the bank.

Because most M.D.s do not understand balance sheets, I have had Mr. Rooney make a breakdown of our total income from all sources, plus a similar breakdown of expenses for the period December 1, 1961 to September 1, 1962. This sheet has been passed to all of you. I will not read the figures, but they are before you for study.

The members of the Finance Committee would welcome constructive suggestions, and would bring any such suggestions before the Finance Committee and, if favorable, to The Council for study and possible adoption.

I could not complete my report without expressing my personal thanks to the Society's Auditor, Mr. Robert Rooney, and the Certified Public Accountant firm of Kenneth B. Knostman, who have spent considerable time in explaining our Society's rather complex financial setup to a would-be perfectionist Chairman.

This year, our Finance Committee has worked hard in an endeavor to be fair to all departments and yet eliminate unnecessary expenditures. The State Society's Finance Committee consists of Drs. Wyman O. Cole, Detroit; J. R. Dehlin, Gladstone; O. J. Johnson, Bay City; C. Allen Payne, Grand Rapids; and D. R. Smith, Iron Mountain, with Dr. William Hyland of Grand Rapids, our State Society Treasurer, in an advisory capacity, and myself as Chairman.

That constitutes my written report. I asked Dr. McGillicuddy if I might add some further remarks to further explain this report. I feel that he was very brave, because he doesn't know what I am going to talk about.

You will notice that we allocate to all departments the salaries. Those salaries are not shown under Expenses but are shown in a lump sum. The item "Annual Session"—we are just starting our Annual Session and only $1,300 of those bills have been paid.

Even though it may look like it, 120 West Saginaw Street is not an "Ivory Tower." Any MSMS member is welcome to come to the Finance Committee and Council meetings. The Finance Committee, even though there are members on it from the Upper Peninsula, has averaged a 90 per cent attendance. We meet for about two hours before every Council meeting, and any member of the State Society is welcome to attend those meetings as well as The Council meetings.

SUPPLEMENTAL ANNUAL REPORTS OF COMMITTEES OF THE COUNCIL

DR. MCGILLICUDDY:

A. Supplemental Annual Report of the Medical Care Insurance Committee

The major work of the Medical Care Insurance Committee this year evolved around two matters referred to it by The MSMS Council.

The Council, in two different actions at its December 13, 1961 meeting, referred to MCIC the matters of (1) M.D. participation with Blue Shield and (2) public representation on the Blue Shield Board of Directors.

It was during The Council discussion December 13, 1961 of the hearings held by the Governor's Study Commission on Prepaid Hospital and Medical Care Plans, that The Council voted to refer to MCIC "the matter of physician participation in Blue Shield for further study."

The other matter was handled by The Council as follow-through on the 1961 House of Delegates action. The 1961 House of Delegates had two resolutions before it, Resolution No. 9 and Resolution No. 32 dealing with Blue Shield Board composition, and voted to refer the matter to The Council for study. The Council then acted to ask MCIC "to consider these resolutions and report its recommendations."

To explore both related matters, the Medical Care Insurance Committee at its February 14, 1962 meeting conferred with Sumner G. Whittier (MMS Executive Director) and G. Thomas McKean, M.D. (MMS Past President). Future study was undertaken at the Committee meeting March 31, 1962 when officers of the Ingham, Oakland and Saginaw County Medical Societies were guests. The Committee members studied the final report of the Governor's Study Commission at its July 18, 1962 meeting before developing the following Annual Committee Report.

The report, chiefly, will deal with:

1. M.D. Participation with Michigan Medical Service.
2. Composition of Blue Shield Board of Directors.

M.D. Participation with Michigan Medical Service.—It is to be noted that the very heart of Michigan Medical Service or Blue Shield is the physician who participates and signs a contractural agreement that he will accept the fees paid by Blue Shield as full fees for services rendered to those in Michigan eligible for Blue Shield M-75 protection.

Without this guarantee of participating physicians who give this full service to eligible Blue Shield subscribers, not a contract could be sold. This means that the doctors who participate with Blue Shield actually support the plan and carry the entire responsibility to make the plan work. Without this guarantee of participation from the doctor and without the issuance of full-service contracts to the eligible subscribers, there would be no Blue Shield. The enabling act does not permit Blue Shield to become another commercial insurance carrier, paying claims only on an indemnity basis.

The Governor's Study Commission on Prepaid Hospital and Medical Care Plans has recommended that "Blue Shield invite osteopathic physicians as full participating physicians." Since 18 per cent of the Blue Shield payments for medical care are made to osteopaths, the Medical Care Insurance Committee feels that this Commission recommendation has much merit. The Committee believes that such a change can be made by Michigan Medical Service by amending its bylaws.

The Governor's Commission Report also states that under the present policy of Blue Shield "it is actually to a physician's financial advantage not to become a Blue Shield participating physician for then he not only collects the scheduled fee for services rendered any Blue Shield patient, but is free to charge more if he so desires." With this statement, the Committee agrees.

The Committee recommends that the House of Delegates reaffirms its action of 1959 that we do agree that payments for services by nonparticipating physicians should be made directly to the patient unless the patient signs an assignment of payment to the nonparticipating physician. This matter was studied in great detail at that time and this procedure continues to have merit.

The Governor's Commission Report also discusses publishing the list of participating physicians in the Annual Report of Blue Shield, such as Blue Cross does with its participating hospitals. Publication of such lists has been a controversial subject for the past several years and has been the subject of debate in recent sessions of the MSMS House of Delegates. The 1961 House of Delegates took action to reaffirm its opposition to the publication of lists of participating physicians in MMS.

In summary, about physician participation in MMS, the Medical Care Insurance Committee respectfully requests the House of Delegates to seriously consider (1) urging both MSMS and Blue Shield to continue efforts to enlarge the number of participating physicians; (2) authorizing that further studies be conducted by the Medical Care Insurance Committee in cooperation with MMS on the matter of physician participation, and (3) recommending that MMS amend its bylaws to permit osteopathic physicians to become full, participating physicians in Blue Shield.

Composition of Blue Shield Board of Directors.—At the present time, the MMS Board of Directors consists of 33 members, which include 20 M.D.s, who are members of the Michigan State Medical Society; 2 M.D.s representing the Michigan Hospital Association; 4 hospital administrators representing the Michigan Hospital Association, and 7 public members. The Governor's Commission Report recommends ". . . that representation of the general public on the Blue Shield Board be substantially enlarged but not be in the majority." The Medical Care Insurance Committee has given considerable study to this subject and suggests that at the present time three more public members be elected to the board and that there be a corresponding reduction in the number of M.D. members. Such an addition in the number of public representatives should increase the public concern about Blue Shield efforts in such areas as enrollment, public relations, finances, et cetera.

The Governor's Commission Report also states that "it does not appear to be in the public interest or in the interest of Blue Shield for a physician to vote in the election of the Blue Shield Board of Directors when he himself chooses not to be a Blue Shield participating physician and hence is not responsible to abide by Blue Shield policy." This observation has sufficient merit, the Committee believes, to warrant consideration by the House of Delegates, which may wish to take action along this line.

The Governor's Commission Report recommends "that once osteopathic physicians become Blue Shield participating physicians, they be entitled to representation on the Blue Shield Board of Directors." The Medical Care Insurance Committee believes this Commission recommendation has considerable merit.

B. Supplemental Annual Report of the Committee to Study Problems of Emergency Care in Hospitals

The Council of the Michigan State Medical Society appointed a committee to study the problem of emergency care in hospitals and authorized a survey for that purpose. Questionnaires were sent to chiefs of staff of 260 accredited hospitals representing 45,245 beds. Returns of the questionnaire were received from 168 hospitals representing 24,635 beds. Survey questions were answered by 54.5 per cent of the total number of beds in hospitals that were queried. Of the hospitals reporting 117 were hospitals with less than 200 beds; 48 hospitals had bed size of 200 or over.

Of the hospitals reporting, 67.9 per cent had organized

emergency room services. However, it is most difficult to define just what is meant by organized emergency room service. There is a minimal type setup that barely qualifies as emergency services. There is in addition a highly organized and efficient emergency room service that reflects creditably on the hospital concerned, and would tend to reduce the in-patient load.

One hundred eleven hospitals, that had organized emergency room service in 1958 and 1961, reported treating 456,913 patients in 1958 and 585,289 in 1961. This represents a 28 per cent increase in three years. One hundred twenty-two hospitals reported a total of 610,126 patients seen in 1961.

One hundred fourteen hospitals answered Question No. 5 concerning how their emergency service was organized, as follows: 22 by house staff; 85 by attending staff; 7 by employed physician.

One hundred thirty-two hospitals answered Question No. 6. Of these, 96 had an established emergency room fee. The fee varied from $1.00 to $10.00; the average fee was $4.06.

One hundred twenty hospitals answered Question No. 7. Seventeen of these reported an additional fee for medical services.

Of the 67 hospitals answering Question No. 8, percentages of patients fell into the following categories as listed: Blue Cross-Blue Shield, 41.4 per cent; Other Insurance, 28.7 per cent; No Insurance, 23.1 per cent; Welfare, 6.8 per cent.

The data submitted unfortunately do not include a sufficient number of returns from large hospitals to give the total picture of out-patient services in Michigan.

A report of a survey made in 1961 by a special committee of the Wayne County Medical Society is included for informational purposes. The figures submitted in this report of the 1962 MSMS survey substantiates the trend toward increased use of emergency room services.

Therefore, this Committee recommends that the results of this survey be placed in the hands of a special committee of the House of Delegates, empowering it and instructing it to study the future developments of this problem in conjunction with the Michigan Hospital Association, Michigan Medical Service, Michigan Hospital Service, and other carriers wishing to participate.

This Committee, having rendered its report, asks to be dissolved.

Following is the report of the survey made in 1961 by the Wayne County Medical Society's Special Committee:

Report from Special Committee on Hospital Emergency Service

To The Council — April 21, 1961

Last Fall on the recommendation of the Review and Arbitration Committee a special committee was appointed by The Council "to make a thorough and immediate study of the problem of hospital emergency service, which is both ethical, moral, and legal."

To carry out this difficult assignment, the Committee attempted first to determine the scope of the problem and how it developed. Next, it tried to evaluate the service from the standpoint of the patient, the physician and the community. Finally, on the basis of these conclusions the Committee formulated recommendations to improve the service and to correct unethical and illegal practices.

Scope of Problem.—To obtain factual and current information, the Committee sent out a questionnaire to all hospitals in Wayne County. 34 hospitals returned the questionnaire and four reported by letter. Herman Kiefer and Lakeside advised they had no emergency service; Metropolitan that its service had been in effect only since June, and Ford Hospital reported until January, 1961, its emergency calls had not been separated from the regular admissions.

Briefly, the summary reveals:

1. That there were 299,321 recorded emergency visits in 1960 in these 34 hospitals.
2. That the number of these visits are increasing.
3. That the majority of the hospitals do try to contact the family physician and send a report to him.
4. That over 50 per cent of the patients have a family physician but come without his knowledge.
5. That over half the patients are seen by interns or residents, and that the trend for hospitals to employ physicians is increasing (12 out of 34).

The Committee considered next the factors in the development of the hospital emergency services. It was agreed:

1. That hospital emergency facilities were originally organized at the request of the police as a service to the community and that they have been continued and expanded to meet the increased demands for this service by both patients and physicians. Growth of hospital emergency service is a part of a nationwide trend and results from changes in medical practice.
2. A contributing factor in the development and growth of these services is the physician. Many of the problems that have arisen have been created by the physician and can only be corrected by him.
3. That the major factor in the expansion of these emergency facilities is the inclusion of these services as benefits under Blue Cross and Blue Shield.

One of the reasons for this increase is the $7.50 basic payment by Blue Cross for cost of operating the emergency room including the services of interns and residents. With a few exceptions this care could be provided better and for less by the private physician in his office.

On the basis of Blue Cross basic charge only ($7.50 per visit) the calls recorded on the questionnaire total $2,250,000 and this figure does not include professional fees or payments for laboratory services.

During the period, January through September in the year 1960, Michigan Medical Service paid $3,747,871 for services rendered in the outpatient department of hospitals. These payments represent 290,739 separate services.

Conclusions.—After analyzing the scope of the problem and the reasons for its growth, the Committee tried to evaluate the service. Is this trend good? Should it be encouraged? The Committee reached the following conclusions:

1. Hospital emergency facilities are an essential service to the patient, to the physician, and the community. These services are growing and will continue to grow.
2. That improvement should be made in the service from the standpoint of quality of care and cost to the patient:
 (a) In over half the cases, the patient is seen only by an intern or resident; this may be satisfactory for a true emergency but it is estimated only 42 per cent* of the cases are emergencies. For complicated emergencies a staff physician must be available. Non-emergency care and diagnostic work can be best provided by a private physician.
 (b) For insured patients the ultimate cost of this care is higher. Although the patient may not be billed for his visit, ultimately he pays more through increased insurance premiums. When Blue Cross-Blue Shield are billed for both hospital and professional fee, the total would be about $12.50. If services were rendered only by an intern or resident or an employed physician, this would represent a dual payment, for their services are included as hospital costs and covered by Blue Cross.
3. Payment by Blue Cross-Blue Shield for emergency services in some hospitals has resulted in unethical and illegal practices by hospitals, physicians and Blue Shield.
 (a) Although hospitals are entitled to a fee for maintenance of the emergency room, they are not entitled to payment for a professional fee.

For general staff funds (interdepartmental) and for

*February *Bulletin*—American College of Surgeons.

educational and research programs, certain hospitals collect fees for interns, residents, and employed physicians. Ostensibly physicians contribute voluntarily to such funds; in reality such contributions are mandatory.

(b) Physicians support these practices by signing Doctors Service Reports for patients they have not seen.

(c) Blue Shield and other insurance companies are paying for services of interns, residents, and hospital employed physicians, which is not in accordance with its contracts. Furthermore, such payment is not made equally to all hospitals.

4. The above misuses of insurance benefits contribute to the costs of Blue Cross and Blue Shield and other insurance companies. To substantiate this conclusion, the Committee asked both Blue Cross and Blue Shield for the amounts of total payments made in the last year for emergency services, but to date only partial information has been received.

5. That outpatient and emergency room services of some hospitals as now carried on in Wayne County represent the practice of medicine by hospitals.

6. The case load includes indigent patients which increase the operating costs of these facilities, a large portion of which is underwritten by Blue Cross-Blue Shield and other insurance companies.

Recommendations.—The Committee submits the following specific recommendations to The Council:

1. That the following policy, adopted by The Council, October 21, 1960, be reiterated and enforced by the Society's Committees—Ethics, Mediation and Review and Arbitration:

"That the Wayne County Medical Society go on record opposing payment to physicians from insurance companies or any other source for services to patients the doctor has not seen."

2. That a copy of this report be sent to the hospital chiefs of staff with the following recommendations for operation of emergency rooms:

(a) Limitation of services as far as practicable to emergency cases.

(b) That a reasonable effort be made to notify the family physician on admission of his patient and in all cases to send a report to the physician about the treatment given.

If the physician wishes the patient to use the services of the emergency room, he may refer the patient, but then he cannot collect for his services.

(c) A private physician on the hospital staff should direct the emergency room and should provide the service to the patient. The physician should utilize for training purposes the assistance of interns and residents as much as possible, but their work must be done under his immediate and direct supervision. The private physician should be paid for his service.

(d) That all money for professional service be paid to the physician rendering service and for patients actually seen by him. If the physician wishes to donate his fee to a special fund, this should be his personal prerogative.

(e) Indigent patients should be directed to public clinics or bills for their care should be sent to the appropriate welfare or civic agency.

3. That a copy of this report be sent to Blue Cross and Blue Shield with the following recommendations:

(a) That limitations now set forth in their contracts be enforced:

Payments only to licensed physicians (who are not interns, residents or employees of the hospital) who personally and directly treat the patient.

Payment for therapeutic services only; no elective diagnostic work.

No payments by Blue Shield for services of intern, resident, or physician employed and paid by the hospital. (This would be duplicate payment, for this service has already been paid by Blue Cross.)

(b) That no benefits be included in Blue Cross-Blue Shield contracts for services in hospital emergency rooms by physicians that are not paid to private physicians in their offices.

4. That since the Special Committee on Hospital Emergency Service has now completed its assignment, it is disbanded.

Recommendations of The Council

We respectfully invite your attention to seven recommendations in the original Annual Report of The Council in your notebook. They read as follows:

1. That The Council be authorized to arrange Councilor Conferences prior to the 1963 Annual Session and thus share pertinent information with the delegates, alternate delegates and component society officers, as during the past five years.

2. That The Council be authorized to prepare, print, and distribute to each member an "Annual Report of MSMS" (including a brief of the financial report) following the general content and presentation used in 1961, to be mailed with the Digest of Proceedings of the House of Delegates.

3. That the House of Delegates urge component societies to continue to hold "State Society Night Programs" and to invite officers and representatives of MSMS to explain MSMS activities. A growing number of such meetings drew plaudits during 1961-62.

4. That The Council requests the House of Delegates again to instruct that MSMS representatives be sent to Washington, D. C., in 1963 on "Michigan Day." The 1962 delegates, as did those in preceding years, reported the Washington trip as important, necessary, educational and productive.

5. That the House of Delegates once again encourage more component societies to send delegations of members to Washington, D. C., to discuss legislative matters with their elected Congressmen. The Council notes that a similar 1961 House of Delegates Resolution did encourage additional component societies to undertake this important legislative project.

6. That inasmuch as national attention is being focused on physical fitness, the House of Delegates select this public problem as one of the top-priority matters for activity by the medical profession in 1962-63. The excellent preliminary work done in this field by MSMS and component societies since the adoption of a similar Resolution last year should be vigorously pushed forward. Moreover, MSMS and component societies should seek to work with other organizations which are also concerned with this national health problem.

7. That the Michigan medical profession give increased support to the Medical Self Help Program of the AMA. This matter is of vital importance to our nation. Component societies should be urged to appoint representatives to aid interested local lay organizations in developing training classes. (It is noted that the Michigan Congress of Parents and Teachers at its 1962 State convention urged its local units to encourage such classes and to work cooperatively with local medical societies and civil defense organizations.)

Further, The Council wishes to present two additional recommendations in this Supplemental Report:

8. That component county societies again be urged to review their respective constitutions and bylaws and to revise them where needed to bring them into harmony with those of the State Society.

9. That the Michigan medical schools be encouraged to increase their teaching and research efforts re alcoholism because of the importance of this problem.

Practice of Pharmacy by Corporations

Information has just been received by The Council to the effect that two different supermarket chains are attempting to obtain drug store licenses from the State Board of Pharmacy.

The Council has also been informed by the Michigan State Pharmaceutical Association that the Kroger Corporation bases its application on acquisition of a corporation, the Owl Drug Company, which had a license before the present law (enacted in 1927) against issuance of such licenses went into effect.

Another company claims the present law to be unconstitutional and has started suit in the Ingham County Circuit Court to force the State Board of Pharmacy to issue it a license, despite the fact that it does not qualify under the present statute, according to the Michigan State Pharmaceutical Association.

On Wednesday, September 26, 1962, at 10:00 a.m., the State Board of Pharmacy will hold a hearing in the Civic Center, at Lansing, at which the arguments for and against issuance of a license to Kroger's "SupeRX Drugs" will be aired.

The Council, being of the opinion that the dispensing of drugs by corporate pharmacies may present a definite threat to the health and welfare of the public, respectfully submits this matter to the House of Delegates which may wish to consider the adoption of a resolution opposing any extension of the practice of licensing the sale of drugs by and through corporate pharmacies.

THE COUNCIL

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ORLEN J. JOHNSON, M.D., *Vice Chairman*
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D. BRUCE WILEY, M.D., *Secretary*
WM. A. HYLAND, M.D., *Treasurer*

O. B. MCGILLICUDDY, M.D. (Continuing): Mr. Speaker and gentlemen, this concludes the first part of the Supplemental Report of The Council. There is one other matter to report on following this.

THE SPEAKER: This portion of The Council's report will be referred to the Reference Committee on Reports of The Council, with the exception of (1) the report of the Medical Care Insurance Committee, which is referred to the Reference Committee on Medical Service and Prepayment Insurance; and (2) the report on the Practice of Pharmacy by Corporations, which is referred to the Reference Committee on Legislation and Public Relations.

IX—C. SUPPLEMENTAL ANNUAL REPORT OF THE COUNCIL (NO. 2)

Report of Committee to Study Headquarters Organization

Your Committee has held three meetings and makes the following report: We recommend that the administration of the headquarters be centralized in the Executive Director. In order to accomplish this, a redefinition in the Bylaws of the duties of the Secretary and Executive Director is required. This necessitates rewriting Chapter 12, Sections 6 and 7 to read as follows:

CHAPTER 12, Section 6 - SECRETARY—The Secretary shall be an active member of the Society. He shall be the recording officer of the Scientific Assembly and Annual Session. He shall perform those duties ordinarily devolving on a Secretary of a Corporation by law as assigned by the House of Delegates and/or The Council.

Section 7 - EXECUTIVE DIRECTOR — There shall be an Executive Director, not necessarily a Doctor of Medicine or a mer ber of the Society, who shall be appointed by and responsible directly to The Council. He shall be remunerated by a salary which shall be fixed by

ADDENDA TO SUPPLEMENTAL ANNUAL REPORT OF THE COUNCIL, 1962

1962 Councilor Conferences

District	Councilor	Date	Place	Staff Representative
1	W. W. Babcock, M.D. Wyman C. C. Cole, Sr., M.D. Wm. S. Carpenter, M.D. Edgar E. Martmer, M.D.	(Several informal conferences with Wayne Delegates)		
2	O. B. McGillicuddy, M.D.	Sept. 12	Lansing	Auer
3	Harvey C. Hansen, M.D.	Aug. 17	Battle Creek	Riley
4	Wm. A. Scott, M.D.	Aug. 16	St. Joseph	Tryloff
5	C. Allen Payne, M.D.	Sept. 6	Grand Rapids	Brenneman & Auer
6	H. H. Hiscock, M.D.	Aug. 21	Flint	Riley
		Aug. 28	Owosso	Riley
7	J. J. Coury, M.D.	Aug. 28	Port Huron	Auer
8	E. S. Oldham, M.D.	Sept. 13	Saginaw	Auer
9	R. V. Daugharty, M.D.	Sept. 13	Cadillac	Riley
10	O. J. Johnson, M.D.	Aug. 29	Pinconning	Wills
11	Wm. M. LeFevre, M.D.	Aug. 30	South of Big Rapids	Riley
12	J. R. Dehlin, M.D.	Sept. 12	Escanaba	Wills
13	D. R. Smith, M.D.	Aug. 29	Iron Mountain	Riley
14	B. M. Harris, M.D.	Sept. 10	Ypsilanti	Auer
15	R. J. Mason, M.D.	Aug. 30	Bloomfield Hills	Campau

The Council. He shall be bonded in amount considered sufficient by The Council, the cost of which shall be paid from the funds of the Society. He shall discharge the following duties:

(a) Collect all annual membership dues, assessments, donations, and such other monies as may be due to the Society; keep membership records and issue membership certificates.

(b) He shall make all required reports to the American Medical Association. He shall make such reports of the proceedings of the House of Delegates as may be required by him.

(c) He shall deposit all funds received in an approved depository and disburse them upon order of The Council. The Council may delegate the authority for disbursing funds to the Executive Committee of The Council. The Council shall cause an annual audit of his accounts to be made by a certified public accountant. He shall render a report to The Council reviewing the Society's activities and imparting recommendations for the advancement of the Society's interests at each meeting of The Council.

(d) Under the direction of The Council and with the advice of the Editor, he shall be the business manager of THE JOURNAL of the Michigan State Medical Society.

(e) He shall superintend all arrangements for the holding of each meeting in compliance with the Constitution and Bylaws and instructions of The Council or its Executive Committee.

(f) He shall send out all official notices of meetings, Committee appointments, certificates of election to office and special Committee assignments.

(g) He shall receive and transmit to the House of Delegates and to The Council the Annual and other reports of Officers and Committees.

(h) He shall institute and correlate each new activity of the Society under the supervision of The Council or its Executive Committee. He shall assist in component County Society integration and furnish information to the public concerning health matters as directed by the President and The Council.

(i) He shall perform such other duties as may be assigned by The Council.

* * *

We are not recommending a successor to William J. Burns at this time, inasmuch as he has well over a year to serve, and we think there should be an opportunity for interested people to apply for the position and for The Council to survey the available applicants.

CLARENCE I. OWEN, M.D., *Chairman*
OTTO K. ENGELKE, M.D.
KENNETH H. JOHNSON, M.D.
ORLEN J. JOHNSON, M.D.
EDGAR E. MARTMER, M.D.
OLIVER B. MCGILLICUDDY, M.D.

THE SPEAKER: The last portion of Dr. McGillicuddy's report, having to do with the duties of the Secretary, deals with a change in the Bylaws, and that portion of the report will be referred to the Reference Committee on Constitution and Bylaws.

V. REPORT OF DELEGATES TO AMERICAN MEDICAL ASSOCIATION

By William A. Hyland, M.D., Grand Rapids, Chairman

There were ninety Resolutions including a last minute one to change the Constitution in order to permit the immediate past President to becoming a voting member of the Board, presented at the session. Seventeen of these resolutions were endorsing the Kerr-Mills and opposing King-Anderson legislation, also thirteen of the Resolutions were related to compulsory Social Security Coverage eleven against and two for it.

Dr. Edward R. Annis of Miami, Florida, Chairman of the Speakers Bureau the past year was overwhelmingly elected President Elect to take office in June 1963 succeeding Dr. George Fister of Ogden, Utah who became President.

There were over 14,000 physicians in attendance with an overall medically connected group of 42,000 in attendance.

Among the many subjects referred to by Resolutions were a Study of the American Board of Abdominal Surgery, Health Care for the Aged, Relations with the American College of Surgeons, Report of the Committee to Study Enlargement of the Board of Trustees, Voluntary Health Insurance for Physicians, Relations of the Association to state societies in regard to medical discipline, hearing of interval report of special committee to study the Communications Division and other subjects.

The report of the Reference Committee on Recognition of the Board of Abdominal Surgeons, which committee held the longest hearing in point of time as also the largest attended was quietly received and approved on the floor. This was somewhat unexpected after the many hours of heated expression and debate in the conference room. The reception on the floor proved again that violent discussions can be well aired in the reference hearings. It is to the credit of the proponents of recognition that they accept the denial of the recommendation of a formation of such a Board in good grace on the floor of the House. This does not mean that the House will not hear more from this group in the future.

In the Session on Health Care for the Aged, there were seventeen resolutions presented supporting the Kerr-Mills program while opposing the King-Anderson bill.

In again affirming its opposition to the King-Anderson and supporting the Kerr-Mills bill, the House gave these reasons:

"1. the lack of need for such a plan.

"2. that it would provide inadequate care for all aged rather than complete care for those who need help.

"3. the fact that inherent in the use of the Social Security mechanism are governmental controls of medical practice which would increase with the expansion of the program.

"4. deterioration of the quality of medical care not only for the aged but for the population as a whole."

In reaffirming strong support for the Kerr-Mills Act, the House declared that "the Kerr-Mills method should be given a fair and reasonable chance to meet the need and thus remove the demand for further Federal legislation."

It urged that in states where existing programs indicate a need for a Kerr-Mills implementing law, each state association should actively sponsor and promote with other responsible citizens the enactment of such a law. It also urged the state associations to "work actively with other responsible citizens in reviewing the functions of the law, evaluating its effectiveness and aggressively supporting improvements in programs to aid those aged who need help so as to achieve the provision of quality medical care and service."

The House took no action on one resolution which called for non-participation in the implementation of the King-Anderson Bill, but it urged individual physicians to give particular consideration to the following sections of the Principles of Medical Ethics:

"Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

"Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has

been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

"Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."

Commenting on the Association's fight against the King-Anderson Bill, Dr. Leonard W. Larson, retiring president, told the opening session of the House that "this great struggle has been testing again whether the science and art of medicine will be permitted to grow and flourish in freedom, or whether progress in medicine will be stunted and shriveled by the excesses of government control."

He declared that the steadfast refusal of the AMA to compromise on basic principles "has been a source of strength for us and our friends." Dr. Larson expressed confidence in ultimate victory, but he added that victory will impose a solemn obligation of responsible leadership for all physicians.

Also commenting on the question of compromise, Dr. Fister in his inaugural address said "we will not compromise with those who regard medical care problems as simply playthings in the game of politics—gimmicks to attract the votes of the gullible."

AMA and State Jurisdiction

To implement one of the major recommendations made by the Medical Disciplinary Committee at the June, 1961, meeting in New York, the House approved a change in the Bylaws under which a proposed Section 1 (B) of Chapter IV will now read:

"In addition to such disciplinary action as may be taken under the constitution and bylaws of the component society and constituent association to which the Member belongs, or when a state medical association to which a member belongs requests the American Medical Association to take disciplinary action, or when at the request of the American Medical Association the state association to which the member belongs consents to disciplinary proceedings by the American Medical Association, the Judicial Council, after due notice and hearing, may censure him, or may suspend or expel any member of the American Medical Association from American Medical Association membership only for an infraction of the Constitution or these Bylaws or for a violation of the Principles of Medical Ethics."

AMA Board of Trustees

The House approved a report of the Ad Hoc Committee on the Board of Trustees which recommended that the size of the Board be increased from eleven members to fifteen members. This will be accomplished by adding three elected members and by including the immediate past president of the Association for a one-year term. The House also accepted a committee recommendation that set the term of office for elected Board members at three years and limited the number of terms to three, for a maximum total of nine years service. To implement the House action, the Council on Constitution and Bylaws submitted changes in the Constitution and Bylaws for consideration at the 1962 Clinical Meeting.

At the June Session it was necessary for the Constitution and Bylaws Committee to change a word in the Bylaws in order for the addition of the Past President to take immediate effect as if it were laid on the table for one year the retiring president of the past year would not have been eligible—due to the yeoman work of Dr. Larson it was the feeling of the House to reward him at this time.

American College of Surgeons

In its deliberations in New York in June 1961 the House stated it was ethical for a surgeon to properly recompense an assisting physician who helped during the operation. This was objected to by the American College of Surgeons as it created the possibility of fee splitting, as in many cases this could possibly be the referring physician.

Attempts by the Board of Trustees of the American Medical Association and the Board of Regents of the American College of Surgeons to clarify this matter have met with indifferent success to date. Dr. Hugh Hussey, Chairman of the Board of Trustees, feels that the two groups are reaching a common ground of understanding and that in the future differences will be attempted to be ironed out in conference rather than in the newspapers; at this time the House restated its June 1961 policy.

"1. Each member of the American Medical Association is expected to observe the Principles of Medical Ethics in every aspect of his professional practice.

"2. Each doctor engaged in the care of the patient is entitled to compensation commensurate with the value of the services he has personally rendered.

"3. No doctor should bill or be paid for a service which he does not perform; mere referral does not constitute a professional service for which a professional charge should be made or for which a fee may be ethically paid or received.

"4. When services are rendered by more than one physician, each physician should submit his own bill to the patient and be compensated separately whenever possible.

"5. It is ethically permissible in certain circumstances, however, for a surgeon to engage other physicians to assist him in the performance of a surgical procedure and to pay a reasonable amount for such assistance. This principle applies whether or not an assisting physician is the referring doctor."

There was a feeling of some that rendering separate bills to the patient might be the answer but it was reported that many insurance groups did not favor this situation, however the Reference Committee did recommend separate compensation whenever possible.

Voluntary Health Insurance

In accepting a Council on Medical Service report on the utilization of state and federal tax funds to provide voluntary prepayment health insurance protection to assist the aged in meeting the costs of health care services, the House approved the following policy statement:

"1. The need for application of the prepayment or insurance principle to protect our people against the costs of medical care is fully recognized and applies to all ages rather than to the aged alone.

"2. Persons financially able to prepay their own expenses are expected to do so and must be encouraged rather than compelled to do so.

"3. Persons financially unable to prepay adequately their expenses may properly be assisted to the degree necessary by their families, their communities, their states, and if these fail, by the Federal government—but in conjunction with other levels of government.

"4. The prepayment system should be devoid of governmental controls.

"5. Dignity and self-sufficiency for the individuals should be upheld.

"6. The protection offered must be reasonably comprehensive rather than token in character."

The House recommended that the Board of Trustees and the Council on Medical Service explore all possibilities, using these principles as a basis.

Miscellaneous Actions

In considering reports and resolutions on a wide variety of subjects, the House also:

Learned that the Board of Trustees has instructed the Council on Drugs to conduct a study on the relationship between *tobaccco and disease.*

Disapproved a suggestion that the Council on Medical Education and Hospitals be replaced by *two separate councils* on undergraduate and graduate medical education.

Referred to the Board of Trustees a proposal that at least six members of the *Council on Medical Education and Hospitals* shall be engaged primarily in the private practice of medicine in hospitals without a medical school affiliation and that no more than four members may be salaried personnel of a medical school or university.

Approved a resolution that *honorariums* be provided for the Association's elected officers in amounts to be determined by the Board of Trustees.

Adopted an AMA Statement of Principles on *Mental Health* and urged all constituent associations to lend active support to the First National Congress for Mental Illness and Health, to be held in Chicago in October.

Endorsed a resolution on *employment of the handicapped,* stating that each individual candidate for employment should be evaluated in light of his ability to perform useful work.

Approved a Guide to the Organization and Operation of *Airport Medical Services* submitted by the Council on Occupational Health.

Endorsed the joint statement on *narcotic addiction* by the AMA and the National Research Council of the National Academy of Sciences.

Urged automobile manufacturers to make *seat belts,* approved by the Society of Automotive Engineers, standard equipment on all automobiles.

Approved a recommendation that *AMA meetings* be scheduled as follows: Annual Meetings—1966, Chicago; 1967, Atlantic City, and 1968, San Francisco, and Clinical Meetings—1965, Philadelphia, and 1966, Las Vegas.

Recommended that the Council on Medical Education and Hospitals conduct a study of *specialty residencies.*

Reaffirmed its opposition to *compulsory coverage of physicians* under the Social Security Act, after receiving 11 resolutions opposing coverage and only two favoring the inclusion of physicians. New York and Pennsylvania put in Resolutions favoring Compulsory but even some of their delegates spoke against it.

Accepted the report of the *Committee on Communications* as information, and, in considering the committee recommendations, suggested that the Executive Vice President present a report of Association activities to the House at each meeting.

Opening Session

At the Monday morning session, the AMA presented a special citation to Jackie Cooper, star of television, stage and movies, for his portrayal of a Navy doctor in the "Hennessey" television program. The 1962 Joseph Goldberger Award in clinical nutrition was presented to Dr. Edwards Albert Park of Baltimore for his investigations of rickets and scurvy in children. Dr. Larson received a plaque for his work on the medical advisory board of the Sears-Roebuck Foundation. The American Medical Association was given awards of appreciation from the Cuban Medical Association in Exile and the Girl Scouts of America.

Inaugural Ceremony

Dr. Fister, in his inaugural address, declared that "we will cooperate, to our very utmost, with government officials, legislators and all Americans who are sincerely interested in finding sound, practical solutions to medical care problems—solutions which include both a respect for medical standards and a respect for the taxpayers." The Distinguished Service Award was presented to Dr. Cecil, and Donald D. Van Slyke, Ph.D., research chemist at the Brookhaven National Laboratories, received the first AMA Scientific Achievement Award honoring outstanding contributions to medicine by non-physician scientists. Mrs. George Papanicolaou was given a special award honoring her late husband's service to mankind.

Wednesday Session

Dr. Fister, in his Wednesday address, assured the House of Delegates, all AMA members and the citizens of this country that "during the next year there will be no letup in our campaign to preserve the high standards of our voluntary, free choice, medical care system." He said that no organization, especially one which thrives on challenge and opportunity to serve the public, can be static.

Election of Officers

In addition to Dr. Annis, the new president-elect, the following officers were named at the closing session on Thursday:

Dr. J. P. Culpepper, Jr., Hattiesburg, Miss., vice president; Dr. Norman A. Welch, Boston, re-elected speaker of the House, and Dr. Milford O. Rouse, Dallas, Texas, re-elected vice speaker.

Dr. Charles L. Hudson, Cleveland, Ohio, and Dr. Wesley H. Hall, Reno, Nev., were re-elected to five-year terms on the Board of Trustees. Dr. Elmer G. Shelley, North East, Pa., was renamed to the Judicial Council.

Re-elected to the Council on Medical Education and Hospitals were Dr. Warde B. Allan, Baltimore, and Dr. W. Clarke Wescoe, Lawrence, Kansas.

Dr. George W. Slagle, Battle Creek, Michigan, was elected to the Council on Medical Service, succeeding Dr. Robert L. Novy, Detroit, who was ineligible for re-election.

For the Council on Constitution and Bylaws, Dr. Walter E. Bornemeier, Chicago, was re-elected, and Dr. James Monroe Kolb, Sr., Clarksville, Ark., was named to fill the unexpired term of the late Dr. Walter E. Vest, Huntington, W. Va.

In choosing Dr. Annis as president the House did a splendid thing for its relations with the public. As chief spokesman for the American Medical Association the past year Dr. Annis is known by millions who have heard him on television, radio and in person.

In his debates with Mr. Reuther many felt he had all the best of it—in his reply to Mr. Kennedy, the evening following the latter's address in Madison Square Garden, Dr. Annis brought out to many just what the discussion was all about and clarified it in many, many minds. In his numerous addresses to executive clubs, union groups, church and welfare organizations as also women's clubs and parent-teachers, he has been constantly on tour. His youth, adaptability and marvelous speaking presentation have made him an outstanding leader and spokesman.

True it is that he did not advance through the ranks, either by way of the House, Board or both as several did who were mentioned as presidential timber but this time is one to close the ranks and put forward the one who can best do the job and this the House did. Your Chairman's opinion coincided with this and he was very happy to be one of the nominating group at Dr. Annis' request.

Scientific Phase

In the scientific phase of the one hundred and eleventh meeting of the American Medical Association held in Chicago June 25 to 29, more interest was created than at any previous meeting.

Possibly the newly designed and built McCormick Building on the lake front made possible a more adequate display of the many subjects.

As usual the pathological display created tremendous interest, being the largest one of its kind in the world. This year the display of pathological specimens of close to immediate removal (being removed in the operating rooms of the largest hospitals) displayed a gross picture of almost *in situ.*

The many demonstrations of the application of treatment facilities created great interest, the intimacy of discussion with the research personnel and teams, also the personal discussion of diagnosis and treatment with those people, of individual cases added a unique and valuable touch.

In the scientific forums and panels, the subject that caused much consternation and was most thought-provoking was introduced by the Chairman of the section on endocrinology, Dr. Edward H. Rynearson, professor of medicine at the Mayo Foundation. He made the following statement while speaking at a panel session: "I address myself to the individual physician who is seeing an individual patient dying of cancer for which every conceivable avenue of treatment has been explored with total failure, and this patient moreover is suffering from excruciating pain and is pleading for release. There are too many instances in my opinion, in which patients in such a situation are kept alive indefinitely by means of tubes inserted into their stomachs or their veins—and the whole sad scene thus created is encompassed within a cocoon of oxygen which is the next thing to a shroud. With all the fluids, vitamins, electrolytes, protein supplements, antibiotic agents, hormones and other preparations available to us now, we can keep people suffering for an indeterminate number of months."

Asserting "there is no treatment for death," Dr. Rynearson said the physician should recommend against "heroic measures" to prolong life in terminal cases if the patient, his relatives or his spiritual adviser do not request the special treatment.

Dr. Rynearson further stated, "a fair group" of doctors at the Mayo Clinic have "very solemnly shaken hands and agreed that under no circumstances will we keep treatment going indefinitely if one of us has an overwhelming stroke and is being kept alive by tubes." This discussion led one news commentator to state, this suggests to the physician to "Let God Take Over." I believe this is the place for the judgment and conscience to take over.

Another paper of utmost interest was one by Dr. Irvin S. Cooper of St. Barnabas Hospital for chronic diseases in New York. A New York teen-age girl was smiling proof of the success of a revolutionary new bloodless surgical technique using extremely cold liquid nitrogen that spells help for hundreds of thousands afflicted with extreme disorders of the nervous system, including Parkinson's disease.

"I feel wonderful," said dark haired Miriam Kimmerman, 13, who last year was an almost completely disabled cripple. Miriam had suffered from a hereditary disease of the nervous system called dystonia, a rare chronic disorder marked by involuntary contortions of the arm, leg and body muscles. But. Dr. Cooper performed two operations on Miriam's brain that have snapped her back to a normal life. She will enter high school this fall as a freshman.

Dr. Cooper has been working for ten years on methods to relieve the rigidity of the muscles and shaking of the body associated with Parkinson's and other nervous disorders. "It is now possible to abolish Parkinsonian tremor and rigidity in properly selected patients with better than 85 per cent chance of lasting success," he stated.

Dr. Cooper's operation consists of drilling a small hole in the skull and through it inserting a five inch cannula, or probe, deep into the area of the brain known as the thalamus, the main relay center for sensory impulses. Liquid nitrogen at about 320 degrees below zero is fed through the tube, freezing and destroying the afflicted brain cells in the area, completely and permanently abolishing all tremor and rigidity on one side of the body. About six months after the operation on one side of the brain, the method is repeated on the other side.

Dr. Cooper showed "before and after" movies of four of his patients from the New York area who had accompanied him to Chicago for the AMA convention. The nitrogen freezing technique had been used on Miriam; on the others, different methods of destroying afflicted brain cells were used.

In the films, John Boyd, 69, who had suffered from severe Parkinsonism, was shown shaking so badly he was unable even to feed himself. Today he walked normally with perfect coordination.

Roy Benson, 11, had suffered from dystonia and had been horribly bent over and distorted. "I can really play baseball now," said Roy, an eighth grader.

Another dystonia victim, Joan Sessa, 15, is now a junior in school. Joan, a pretty brunette, looks and acts perfectly normal. Said Joan's mother, Mrs. A. C. Sessa: "It is almost a miracle."

A discussion that held exciting interest concerned a revolutionary technique, viewed as holding promise as an aid to ailing hearts starved for blood. Dr. David Movitz, 49, assistant professor of surgery at the Chicago Medical School, told about the procedure at one of the scientific sessions. So far, the technique has been tried only on dogs but studies are going forward at the school aimed at its possible use on humans, it was explained.

The procedure involves removing the spleen, and inserting fragments of that abdominal organ in between the two layers of the heart. In that position, the spleen tissue, which is rich in blood vessels, takes root and grows to provide an additional blood supply by establishing what is called collateral circulation. In an interview, Dr. Movitz said he reproduced in the animal hearts an abnormal condition called splenosis, which occurs in humans when the spleen is ruptured or torn.

This disease develops when small pieces of a ruptured spleen are carried throughout the abdomen by hemorrhage to implant themselves on the lining of that cavity. The same fragments then start growing and draw their blood supply from underlying tissue. Dr. Movitz noted that this fresh growth of spleen material substantially increases the blood flow. He reported that this condition developed in the pericardium, or outer heart walls, of five dogs on which he has tried the experiment so far. Dr. Movitz emphasized that although the investigations are still in a preliminary phase, the finding that spleen particles can be implanted into living hearts to enrich their blood vessel supply may open the way for a new surgical approach in treating humans. Should the procedure be perfected, it would be of particular benefit to victims of coronary occlusion.

In another report at the meeting, Dr. Herbert E. Kaufman of the University of Florida at Gainesville, told for the first time how a previously announced drug is able to kill one kind of virus as easily as antibiotics knock out certain types of bacteria. The substance, called 5-Iodo 2- Deoxyuridine, is the first chemical agent ever found effective against any virus caused disease. Dr. Kaufman, an ophthalmologist, said the compound is being modified for tests against many virus diseases and some forms of cancer.

At the present time, the compound, also known as IDU, is effective only when it can be brought into direct contact with a virus infected cell. The drug is a synthetic substance developed four years ago at Yale University for possible use against cancer. Known as an antimetabolite the drug tricks living cells and viruses into using it as a false building block needed for virus reproduction. "This is the first specific agent effective against any true virus disease in animal or man," Dr. Kaufman said.

Dr. Kaufman said that DNU gets in its killing action by stopping viruses from going through the last step in using a cell's substances to fashion a complete virus molecule. The drug, he explained, shows promise only against viruses that contain what is called nucleic acid, otherwise known as DNA, formed in the heart or nucleus of a cell.

A group doing research in coronary disease reported their technique in using the left internal mammary artery to provide blood supply for the degenerating coronary vessels of the heart with enthusiastic results.

It also gives your narrator extreme pleasure to report Dr. Harold Falls of your Council and his group from Ann Arbor were awarded the coveted Billings Medal for their exhibit showing the close co-relation between the hand and eye as an aid in the diagnosis of internal diseases.

Discussion on Tension Peaks followed by Heart Attacks within six months to three years were very interesting when portrayed as warning periods in which prophylactic adjustment has been felt responsible for avoiding cardiac failure in many cases.

The new large mental health program to be initiated this fall as well as the Cigarette study program were announced as some of the subjects in the immediate offing.

An exhibit of artificial hearts with which dogs have survived for twenty-four hours, drew crowds to the display. So far, all the dogs have died as a result of blood clots formed inside the device, according to Dr. Willem J. Kolff, Cleveland, a member of the exhibiting group.

An implantable silicone rubber capsule capable of storing a drug, keeping it dry and releasing it slowly into the body was demonstrated by Lieutenants Judah Folkman and David M. Long, U. S. Naval Reserve Medical Corps, Bethesda, Md. The capsule is capable of holding a three to four year supply of insulin and could also be implanted in inoperable bone tumors to dispense nitrogen mustard locally in small doses over a period of days or weeks, they reported.

An extremely interesting paper was given by a California scientist, who advocated coronary research groups in hospitals which could save at least one hundred thousand lives yearly of the patients who enter hospitals for cardiac and other troubles.

There were numerous other interesting scientific panels and studies that space does not permit recounting at this time but most of which will be published in coming numbers of The Journal of the American Medical Association.

Wm. A. Hyland, M.D., *Chairman*
Wm. Bromme, M.D.
R. L. Novy, M.D.
G. W. Slagle, M.D.
J. R. Heidenreich, M.D.
O. J. Johnson, M.D.
L. R. Leader, M.D.
C. I. Owen, M.D.
R. E. Rice, M.D.
D. N. Sweeny, Jr., M.D.
G. B. Saltonstall, M.D.
J. M. Wellman, M.D.
Sidney Adler, M.D.
B. M. Harris, M.D.

The Speaker: The report of the Delegates to the American Medical Association House of Delegates will be referred to the Reference Committee on Reports of Officers.

VI. REPORT OF WOMAN'S AUXILARY TO THE MICHIGAN STATE MEDICAL SOCIETY

By Mrs. C. I. Owen, Detroit, President

Mr. President, Mr. Speaker, Members and Guests:

It is a real privilege to come before you this evening to tell you in a few words our Auxiliary story, when and why we were organized, and some of our accomplishments.

Back in 1927 the MSMS saw the advantage of having an Auxiliary to assist in entertainment at conventions, to promote acquaintanceship among physicians' families, and to do such work as may be approved or assigned by the MSMS. Thus, at the request of the parent Society, the Auxiliary was organized by twenty-eight loyal and dedicated doctors' wives.

Today we have a membership of 3,311, or about one-half of our potential. We have all sizes of auxiliaries; the smallest has eight very active members, and the largest has over 600 with a great many inactive members.

In our State we enjoy a diversified program geared to the needs of the community. This year special emphasis has been placed on AMA-ERF, Careers, and Legislation.

Our AMA-ERF Chairman was a very alert and energetic woman, always ready at the drop of a hat to go to the farthest corner of our State to explain its purpose and how this fund is used to further the education of our young people today. Nearly all the counties have increased their giving. This was accomplished by bridge parties, style shows, theater parties, playing card sales, and many other methods. This year we exceeded our last year's amount by $1,750.76. Michigan was sixth in the entire nation. A total of $244,172.35 was raised for AMA-ERF by the Auxilaries of our fifty States.

All of our efforts were not spent on money-raising projects. We are fortunate to have as our Legislative Chairman a member of the State Bar of Michigan. We know that as good citizens we have a definite job to do. We must be well informed on all the political issues that undermine our economy and those individuals who are trying to socialize medicine bit by bit.

Our Chairman has toured the State extensively, explaining the various issues and stressing the fact that good medicine cannot survive the assembly-line technique. This is a wonderful field of joint endeavor for the doctor and his wife. Any legislation that affects the doctor affects his family also. It is up to the doctor and his wife to decide which team will win—certain political issues, or the doctors' health plan. Both the doctor and his wife are urged to support AMPAC for better government.

Mental health has played a big role in our program this year. Many counties have devoted at least one meeting to various aspects of mental health, such as mental health in art, drama, gardening, music and special education. Some counties have developed programs to assist their senior citizens, while others were interested in working toward the establishment of a children's ward in mental hospitals.

Our Civil Defense Chairman has worked diligently this year to alert the counties to the need of preparation and education. Her advice is: Be Informed, Be Prepared, Be Resourceful, Be Calm and Be Organized.

Much has been said and written about our Driver Education courses, seat belts, safety in the home and on the farm, as well as on the highways and at the beaches. Poison control programs have been very popular throughout the State.

Through community service the doctor's wife has played a very important role in her community. Many members are active in hospital auxiliaries, PTA, Girl Scouts, Den Mothers, Volunteer Nursing, World Medical Relief, Cancer Detection and Diabetic Clinics. To all of these and many more, our members have rendered a valuable service that cannot be estimated in dollars and cents.

Our newest project is "International Hospitality." East is East, and West is West, and the twain DOES meet in some of our Michigan homes. To date, 122 doctors and their wives, representing thirty-six different countries, have partaken of some form of hospitality in our homes. Some have enjoyed an evening at the opera, others at a ball-game, or a tour through our art museums, while others enjoyed some of our picturesque scenery in Michigan, or a quiet evening watching color television. The doctors involved are here for further training at various hospitals and institutions. As they go back to their native lands we hope they will carry with them many happy memories of the time spent in Michigan, and with the knowledge that we really do believe in "Peace on earth, good will to all men."

We have accomplished all of this with less than half of our potential. The fact that you delegates are here tonight tells me you are key men and that you are vitally interested in your county society as well as your State Society. Will you please use your influence and alert your own county society to the need of increasing your Auxiliary membership? Find out if your wife is a member and, if not, why not. If she cannot be active, her name on our membership rolls will denote she is interested in your profession and her dues will help carry out our worthy projects.

I could not close this report without taking this opportunity to give special thanks to Mr. Burns and his entire staff at our East Lansing headquarters, for the indispensable assistance and support they have given me this year, and also to Mr. Scott and his staff at the regional office in Detroit.

Again, my sincere thanks.

THE SPEAKER: Mrs. Owen's report will be referred to the Reference Committee on Reports of Officers.

VII. REPORT OF MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

By Cecile D. Rutan, Hanover, President

The fifth annual convention of the American Association of Medical Assistants was held in Reno, Nevada, October 1961. Michigan sent four delegates and two alternates. In addition we had twenty other members who attended this meeting.

In November, the President's Conference was held at Flint, with a registration of ninety county officers and committee chairmen attending.

In February, four of our members attended the MSMS County Secretaries-Public Relations Seminar at Lansing.

On February 28, 1962, we held our fifth annual Educational Seminar in Detroit. For the past three years this Seminar has been planned and directed by our own members. This year Dr. George Lowrey, Director of Poison Control Center, University Hospital, Ann Arbor, presented the Annual L. Fernald Foster, M.D. Memorial Lecture. We had 117 registered for this meeting.

In May 1962 the Michigan State Medical Assistants sent their President and President-elect to Windsor, Canada, to attend the annual meeting of the Ontario Medical Secretaries Association. It was through the assistance of the MSMAS and Dr. J. Edward Manning, of Saginaw, that this group was organized.

In May 1962 the second President's Conference was held in Lansing. The theme of this meeting was "Medicine—The Backbone of Michigan," with local doctors of Lansing as speakers. We had fifteen component societies represented at this meeting, with a total registration of 103.

All twenty-two component societies have continued to be active in civic affairs. Each county society has had one meeting on civil defense, with a representative from the Civil Defense office talking to the group; one meeting on the H.R. 4222 bill, with the playing of the Ronald Reagan record and a doctor of their county medical society talking on the bill. Each member has been urged by the county, state and national presidents to write letters to their congressmen, opposing H.R. 4222.

At the Statler-Hilton Hotel, September 27, 1962, the MSMAS will hold its annual meeting, with the business meeting beginning at two o'clock and the banquet in the evening. We are hostesses for the American Association of Medical Assistants. The AMA House of Delegates will convene on September 26, 1962, at the Statler-Hilton Hotel. The scientific meetings will begin September 28 and will run through the 30th. We are expecting over 600 at this meeting. At this time we want to thank The Council of the Michigan State Medical Society for its generous contribution to the AAMA Convention Committee.

MSMAS has a candidate on the AAMA slate, and we have submitted Dr. Glenn E. Millard's name for the Advisory Committee.

This year marks the thirteenth year of organization for our Society. We have twenty-three component societies. We welcome a new component society this year, Midland County, which was organized this year.

Our membership is over 900, of which 190 are new members.

The membership trophy which was presented by our Advisory Committee was won last fall by Eaton County. This award is based on the county with the greatest membership increase percentage-wise.

Our Bulletin has continued to be published quarterly, as in the past. Manuscripts and lectures from our various functions have been published.

For two years Michigan has won the trophy at the AAMA convention for the best printed Bulletin. This year for the first time, MSMAS will be giving a plaque to the county with membership over fifty for the best county Bulletin, and one to the county for the best Bulletin with membership under fifty.

This will make the third year that the MSMAS will elect and honor a Medical Assistant of the Year. The Assistant is chosen on activities in her local society, congeniality, leadership, and ability to work with others. The award is presented by the Medical-Dental-Hospital Bureau of America.

This year we will finish up the In-Service Training Pilot Study through the Extension Service of the University of Michigan. We have had fifty-two who have received certificates for this three-year course. The courses are now being offered in the following places: Battle Creek, Ann Arbor, Detroit, Grand Rapids, Jackson, Lansing, Port Huron and Saginaw, with a total enrollment of 250. This year the AAMA will have a trial run examination to help evaluate the educational courses.

The Michigan State Medical Assistants Society greatly appreciates the interest and cooperation of The Council of the Michigan State Medical Society and of the many others who have so graciously given of their time this past year. We also want to thank you for the privilege of using the MSMS building for our Executive Board meetings. We are most grateful to the county medical societies and advisory committees for their assistance.

May I take this opportunity to invite you to the MSMAS and AAMA functions at the Statler-Hilton Hotel, September 26 through September 30, 1962. I will be most happy to greet you at any of the meetings.

THE SPEAKER: These remarks will be referred to the Reference Committee on Reports of Officers.

VIII—A. REPORT OF MICHIGAN MEDICAL SERVICE

SIDNEY ADLER, M.D.: You have all been given a copy of my formal report which I gave to The Council on July 20, 1962. This is in your Handbooks, and I shall not attempt to read this since it is quite lengthy and detailed.

VIII—B. SUPPLEMENTAL REPORT OF MICHIGAN MEDICAL SERVICE

Because of recent events, I would like to spend a little time in giving you the story regarding the National Senior Citizen Contract. Reading what appeared in the newspapers recently certainly would not have given you the whole story.

The first week in January, 1962, the National Blue Cross Association and the American Hospital Association announced a proposed National Senior Citizen Contract. During this same week, the National Association of Blue Shield Plans announced a National Senior Contract which had the endorsement, in principle, of the American Medical Association. On February 2, 1962, we reported as much information as we had at that time to The Council of the Michigan State Medical Society.

We had many misgivings about the National Contract, especially its pooling proposals and anticipated cost. On the 1st through the 3rd of April we vigorously questioned the plan at the annual business meeting of the National Association of Blue Shield Plans in Colorado Springs. As a result, some modifications were made in the National Blue Shield program, although the cost factor was never resolved satisfactorily.

The Council was given a full report on the Colorado sessions at its April 18 meeting, and a status quo report on May 16.

The Enrollment Committee of the Michigan Blue

Shield Board held several meetings exploring the basic national program provisions and fashioned a single contract proposal for Michigan's first offering.

The Board of Directors of Michigan Medical Service approved this national program on May 23, 1962. It contained a $4,000 family income provision based on the $2,500 Plan A fee schedule. It also contained 70 days of medical care in hospitals, thirteen weekly visits to nursing homes, radiation therapy, laboratory and pathological services, and other benefits.* A specific rate of $4.12 was approved at which this contract was to be offered.

The Enrollment Committee's motion read:

"That this Committee recommend that the Board approve the preparation of this National Senior Citizen Contract to be held in abeyance for use if and when the National Blue Cross Association and the National Association of Blue Shield Plans proposals are announced. This statement is subject to revision in the event there is a change in status quo. This resolution is to be transmitted to NABSP."

The Board voted this motion and then amended it to clarify its intent:

"The intent of the above action being that Management be authorized to present this to the Insurance Department for approval, if deemed necessary, in order to meet the NBCA and NABSP announcement of the availability of the National Senior Contract."

On June 14, 1962, the National Blue Cross Association released the specifications of its National Senior program. It contained two contracts. One was a high option plan, complementing Blue Shield's national plan, with 70 days' hospitalization plus nursing home benefits and visiting nurse provisions. The other was a low option plan similar to our present Senior Citizen Contract which contains 30 days' hospitalization.

At the annual meeting of The Council on July 20 I made my report which appears in your Handbook. At that time neither the Blue Shield Board of Directors nor I had any knowledge of the new variations in the contract proposals.

These variations, namely, the high-low optional plans, were presented to the Executive Committee of MMS for information only on August 22. It was the first time that ANY member of the Board of Directors had any knowledge of the variations, which included a higher set of rates.

Blue Cross had filed tentative contracts on the high-low option, with rates, with the Insurance Commissioner on August 20. While Michigan Medical Service did not formally file until August 23, our proposals were made known to the Commissioner, rates and benefits, by Management on August 10—on a work paper. These were not the final figures but tentative figures to be discussed before Blue Shield's Executive Committee, Enrollment Committee, or Board of Directors were informed. Management had filed the programs with the legal authority it had based on the vote of the Board on May 23.

On August 29, at the monthly meeting of the Board of Directors, the members were presented with the information on the national contracts already filed with the Insurance Commissioner. The change in rates was explained to be the result of a more sophisticated rating procedure based on better data.

On September 11, Michigan Medical Service released a detailed report to Dr. Engelke, President of the Michigan State Medical Society, and to the Blue Shield Board of Directors, reviewing step by step what had happened to that point.

On September 17 the Michigan State Medical Society, through Dr. Engelke, informed the members of the House of Delegates and the county medical societies of the occurrences of the preceding week.

The Insurance Commissioner issued a press release on Friday night, September 7, announcing that a 50 per cent rate increase was being asked on Senior Citizen contracts. We never got ahead of that headline for many and sundry reasons.

Lest there be any doubt about it, Michigan Medical Service continues to have an abiding interest in providing realistic, adequate care for our senior citizens. Despite the newspaper accounts and other confusing reports, no contracts now held by senior citizens have been or will be cancelled. No rates have been raised on a single contract now held by an elderly citizen in the State.

At the last meeting of the Board of Directors of Michigan Medical Service, the Board acted to postpone the sale of all non-group contracts—for persons both under and over the age of 65—pending further study.

There are approximately 640,000 people over the age of 65 in Michigan. Of these, about 240,000, or 38 per cent, are protected by Blue Shield coverage of various types. We are proud of the fact that we are one of the few who cover senior citizens with one of the broadest and most realistic scopes of benefits anywhere in the nation. To the best of my knowledge, we are the only ones who never cancel for excessive usage. We have four plans for this age group, with monthly subscription fees ranging from $2.35 to $3.24. The national program called for new contracts with slightly different benefits, and none of our present aged subscribers were to be affected, except by their own choice.

Michigan Medical Service will make every effort in the months and years ahead to expand and improve the health care protection of Michigan's elderly in the same spirit which pioneered this protection in the past. This will be based on balancing the scope of benefits, maintaining a good quality of medical care, and on a valid economic basis. There must be a balance between idealism in health care and practicability.

Before I close I must talk about a very important situation which faces Blue Shield. It is a paradox which I have been talking about for the last several years. Our enrollment—the number of subscribers—has been increasing. These two factors compound themselves and thus are reflected in one way—cost.

Let's look briefly at our utilization and what it costs. A comparison of M-75 for the year 1961 with 1960 indicates that the frequency of service per contract rose approximately 8 per cent with a corresponding 8 per cent increase in cost. An analysis of the first quarter of 1962 reveals a more startling pattern with frequency of services per contract rising in excess of 15 per cent with a corresponding 10 per cent increase in cost. These facts and projections are at variance—wide variance—with original forecasts.

The question that comes to mind with these statistics is obvious. If this is good quality care, we have nothing for which to apologize. We have the mechanism of the county medical societies, through their review committees, to assure the subscriber that the highest quality of medical service was rendered. In many areas these committees have done an outstanding job.

When Class II services were introduced, many so-called experts proclaimed that the doctors would increase their office x-ray utilization. It has been just the contrary. Use has increased at a lesser rate in the doctors' office than in the hospital. For example, the cost of diagnostic x-ray per contract for 1961 as compared with 1960 increased over 10 per cent in hospitals and only 6 per cent in the doctor's office.

Thus, common sense impels me to ask another question: Where is the money going? For what? And why? The "why" answer is gradually coming into focus as we study this problem in depth. Needless to say, we are watching these trends very closely, and a careful analysis continues as to the frequency of medical services rendered. We are currently in the process of pinpointing these problem areas by plan, by medical benefits, by diagnosis in every group. The services rendered are valid. We make continuous audits with our subscribers, and our reports confirm this.

Make no mistake about it—Blue Shield knows it must

*Surgery anywhere, anesthesia, first aid, diagnostic x-ray.

get the answers to the enrollment and utilization problems. Your Board of Directors is aware of these trends, and we have been making every effort to keep the physicians of Michigan as informed as possible of these important and vital developments.

There are many more points which I could take the time to discuss, but I have included them in my formal report which I invite you to read if you have not already done so.

MMS was formed by physicians to provide a gradually increasing scope of benefits for the people of Michigan at a fee schedule which, in many areas, was subsidy by the physicians. We have not altered these idealistic aims and goals.

I have done my best to be actual and factual. I shall continue to do my best in the capacity of President of Michigan Medical Service.

THE SPEAKER: Dr. Adler's remarks will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

MONDAY MORNING SESSION

September 24, 1962

The second meeting of the House of Delegates convened at 9:10 a.m., Vice Speaker H. F. Falls, M.D., presiding.

XI. AWARDS

XI—A. REPORT OF THE COMMITTEE ON "CERTIFICATES OF COMMENDATION"

By R. W. Teed, M.D., Ann Arbor, Chairman

The Annual Report of this Committee is printed in the Handbook.

XI—A (1) SUPPLEMENTAL REPORT OF COMMITTEE ON "CERTIFICATES OF COMMENDATION"

At its 1961 session the House voted to abolish the Foremost Family Physician Award and in its place resolved:

"That the House of Delegates of the Michigan State Medical Society, through a committee to be appointed by the Speaker of the House of Delegates, establish and award Certificates of Commendation, which may include both scientific and/or public service, and which may be awarded to one or several physicians annually who distinguish themselves in the medical profession."

Your Committee, composed of Drs. L. A. Drolett, A. E. Heustis, A. B. Levant, W. J. Stapleton, G. H. Scott, W. N. Hubbard and R. W. Teed (Chairman), held two meetings in an effort (1) to establish policy for the group, and (2) to select nominees for consideration by the House.

The Committee first discussed the policy of selecting nominees on the basis of specialties, but decided that the awards should be to those "who distinguish themselves in the medical profession," without regard to specific divisions or classifications. The Committee recommended, however, that awards be limited to members of the medical profession who practice in Michigan and who are members of MSMS.

The Committee discussed the various types of certificates, citations, scrolls, plaques, and so on, that might be awarded, and recommended that this award should be in the form of a scroll, suitable for framing and hanging. The award should be known as "Commendation for Outstanding Contributions to Medicine in the State of Michigan," with a brief digest of the nominee's specific contributions on the scroll. In addition, a detailed account of his contributions should be presented along with the scroll. The Committee felt that the scroll should be developed in diploma style, with Old English lettering and no color illumination.

The Committee recommended that the actual presentation of the awards should be made on the day following acceptance of the Committee report by the House of Delegates. The awardees would present themselves in the House of Delegates, where the Speaker of the House would award the scrolls.

The Committee discussed at length the various methods of securing nominees in future years, but did not feel that it would be desirable to bind any future Committee with any rules in this regard. It was felt, however, that any member of the Michigan State Medical Society, having a nominee considered worthy of this award, should be urged to send his recommendation and listing of qualifications of such nominee to the Speaker of the House for reference to this Committee.

In order to prevent political pressures on the Committee from groups promoting a single individual, the personnel of the Committee should be kept secret throughout the year.

The Committee reviewed at length a number of nominees, and after full and free discussion selected for presentation to the House the names of the following four members of MSMS for election to this award:

Jerome W. Conn, M.D.
G. D. Cummings, M.D.
Charles S. Kennedy, M.D.
Robert L. Novy, M.D.

Abstracts of the attainments of these nominees are appended and have also been circulated to the delegates; hence, they will not be read at this time.

Mr. Speaker, your Committee recommends:

1. That in order to expedite the task of alerting and presenting the awardees to the House in 24 hours, that the rules be suspended and that the nominees be voted upon at this time, and

2. That the remainder of the report be referred to a reference committee as usual.

THE VICE SPEAKER: Thank you, Dr. Teed. The Vice Speaker invites the attitude of the House of Delegates. May I hear a motion?

L. J. BAILEY, M.D. [Wayne]: I move approval.

F. P. RHOADES, M.D. [Wayne]: Second the motion.

[The motion was put to a vote and was carried unanimously.]

R. W. TEED, M.D.: The House is now constituted as a committee of the whole, and further comments or nominations will be accepted.

F. P. RHOADES, M.D.: Dr. Teed, I move that nominations be closed.

[*The motion was severally seconded, was put to a vote, and was carried unanimously.*]

L. J. BAILEY, M.D.: I move we rise and report to the House the action of the Committee.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

THE VICE SPEAKER: It is my interpretation that the slate Dr. Teed presented was accepted by the House. I will accept any particular criticism or alteration in this interpretation. If there is none, the slate has been accepted as a whole.

THE VICE SPEAKER: The report of Dr. Teed's Committee will be sent to the Reference Committee on Special Committees.

XI—B. 50-YEAR AWARDS

By President Otto K. Engelke, M.D., Ann Arbor

One of the more pleasant duties of your President is the conferring of 50-Year Awards upon men who have demonstrated the exceptional quality we expect in the public service contributed by physicians to the citizens of the State of Michigan. Included in the list this year are:

County	*Awardee*
Allegan	Willard R. Vaughan, M.D., Plainwell

County	*Awardee*
Houghton-Baraga-Keweenaw	Alfred LaBine, M.D., Houghton
Ingham	Earl I. Carr, M.D., Lansing Leo G. Christian, M.D., Lansing*
Kent	Edward D. Hunderman, M.D., Grand Rapids Elmer W. Schnoor, M.D., Grand Rapids John N. Wenger, M.D., Coppersville
Manistee	Homer A. Ramsdell, M.D., Manistee
Muskegon	William S. Chapin, M.D., Muskegon Heights C. B. Fleischmann, M.D., Muskegon Vilda S. Laurin, M.D., Muskegon
Oakland	E. Kyle Simpson, M.D., Chatham, Ontario
Ottawa	Cornelius E. Boone, M.D., Zeeland
St. Clair	Marion E. Bovee, M.D., Port Huron Thomas Henry Cooper, M.D., Port Huron Clarence D. Selby, M.D., Port Huron
Sanilac	John C. Webster, M.D., Marlette
Wayne	Julius Y. Burnstine, M.D., Detroit George C. Burr, M.D., Detroit Edward K. Carmichael, M.D., Detroit Clair L. Douglas, M.D., Detroit Edmond J. Durocher, M.D., Ecorse Clarence H. Eisman, M.D., Grosse Pointe George A. Ford, M.D., Detroit Ledru O. Geib, M.D., Detroit Leo E. Grajewski, M.D., Detroit Ellis R. Green, M.D., Detroit Willard B. Howes, M.D., Royal Oak Charles W. Husband, M.D., Detroit Carey P. McCord, M.D., Ann Arbor Hugh A. McFadyen, M.D., Detroit Lyman J. Pinney, M.D., Detroit Paul C. Rohde, M.D., Detroit George Sewell, M.D., Birmingham Rudolph G. Tenerowicz, M.D., Detroit

*Died September 1, 1962.

Three of these men are here today to receive their awards in person, and they are before you. The awards will be conferred by the Society Secretary as I call the names of these three gentlemen. Dr. Cornelius E. Boone, Zeeland. Dr. Marion E. Bovee, Port Huron. Dr. Elmer W. Schnoor, Grand Rapids. [*Applause*]

There are certain times in our deliberations when we utilize the services of tellers to count ballots. The tellers for this session are: H. E. Lichtwardt, M.D., Oakland, *Chairman*; E. M. Vardon, M.D., Wayne; Noyes L. Avery, M.D., Kent; Jack Rom, M.D., Wayne.

We are also appointing Dr. L. J. Bailey as Parliamentarian.

XVI. TRIBUTE TO DECEASED MEMBERS

Secretary Bruce Wiley, M.D., read the list of members of the House of Delegates deceased in 1962, as follows:

County	*Former Member*
Ingham	L. G. Christian, M.D. 1933 through 1937 1941 - 1942 1944 through 1950
Kalamazoo	Warren B. Crane, M.D. 1950 through 1952 [*Alternate*]
Kent	A. B. Smith, M.D. 1940 through 1944 Arthur A. Van Solkema, M.D. 1945 [*Alternate*] 1947 through 1953
Livingston	Hollis L. Sigler, M.D. 1943 through 1946 1947 [*Alternate*]
Mecosta-Osceola-Lake	Thomas P. Treynor, M.D. 1946 through 1950 1945 [*Alternate*]
Wayne	A. E. Catherwood, M.D. 1937 - 1938 1940 through 1948 George H. Andries, M.D. 1941 through 1943 1945 - 1946 1944 [*Alternate*] Norman K. H'Amada, M.D. 1938 [*Alternate*]

The House arose in silent tribute to these departed members.

X. RESOLUTIONS

X—1. MEDICAL CARE INSURANCE

R. R. Cooper, M.D. [Wayne]:

Whereas, prepaid health insurance has proved to be an efficient and economical method of providing the best in medical care, and

Whereas, it is appropriate for the medical profession to propose constructive, progressive and realistic action; therefore, be it

RESOLVED: That the Michigan State Medical Society support the principle of government subsidy of privately administered prepaid medical care through the medium of income tax credit for individuals below a defined income level or in full for eligible persons who do not pay income tax, and that benefits under such insurance contracts be similar to those normally provided for this average income group in various areas; and be it further

RESOLVED: That the Michigan State Medical Society present this resolution to the American Medical Association and that copies be forwarded to the senators and representatives from Michigan.

The Speaker: This resolution will be referred to the Reference Committee on Legislation and Public Relations.

X—2. NEW POLL ON SOCIAL SECURITY

Don McLean, M.D. [Wayne]:

Whereas, the House of Delegates of the Michigan State Medical Society in 1961 authorized a poll of the members regarding Social Security, and

Whereas, the questionnaire was faulty and subject to misinterpretation, and

Whereas, the results of this poll were grossly misrepresented to the House of Delegates of the American Medical Association; therefore, be it

RESOLVED: That the Michigan State Medical Society again poll its members in regard to their opinions on inclusion in Social Security.

The Speaker: This will be referred to the Reference Committee on Resolutions.

X—3. ESTABLISHMENT OF CERTAIN NEW CLASSES OF MEMBERSHIP

H. A. Scovill, M.D. [Washtenaw]:

Whereas, the Washtenaw County Medical Society has long been aware of the presence in the State of Michigan of many doctors of medicine in academic or industrial

teaching, research or administration who do not hold a license to practice medicine in Michigan because they are not directly concerned with patient care, and

Whereas, there are doctors of medicine in this State who are in the process of achieving citizenship and hence for a period of years are permitted a temporary license to practice medicine in Michigan, until such time as full citizenship be granted, and

Whereas, there are also doctors of medicine in this State who are regularly licensed in another state, and who are active members in good standing in the medical society of that State, but who, while pursuing postgraduate studies in Michigan, are granted a temporary license to practice medicine, and

Whereas, the Washtenaw County Medical Society has received an opinion from the Legal Counsel of MSMS that election of such persons to active membership would be in violation of the Bylaws of MSMS and the AMA, and

Whereas, the Washtenaw County Medical Society believes that such persons should be granted membership equivalent to active membership, rather than associate membership which is essentially a temporary status (see Chapter 5, Section 3(d)), and

Whereas, the Washtenaw County Medical Society believes that many of these persons would be happy to associate themselves on an equal basis with the local society, and

Whereas, the Washtenaw County Medical Society believes that its members also would benefit from the association and experience of these persons; therefore, be it

RESOLVED: That in order to accomplish these ends, the Constitution and Bylaws of MSMS be amended as follows:

1. That Article VIII, Section 1 of the Constitution be amended to include, after the phrase "This Society shall consist of Active Members . . .", the words "non-licensed Members," and after the words "retired members" the words "Non-Resident Members." [This last is to correct a previous error.]

2. That Section 1 of Chapter 5 of the Bylaws be deleted, and that in its place the following be substituted:

Section 1. Active Members. Active Members of this Society shall comprise doctors of medicine regularly elected to such membership by the several component county societies. To be eligible for active membership, a doctor of medicine must, in addition to compliance with all other provisions of the Constitution and Bylaws of this Society:

(a) Hold an unrevoked license to practice medicine, surgery and midwifery in Michigan by authority of the Michigan State Board of Registration in Medicine, or

(b) Have filed first papers for citizenship in the United States, hold an unrevoked temporary license to practice medicine, surgery and midwifery in Michigan by authority of the Michigan State Board of Registration in Medicine, pending achievement of full citizenship, or

(c) Hold an unrevoked license to practice medicine, surgery and midwifery in a state other than Michigan, be an active member in good standing of the society of the state in which he holds such license and hold an unrevoked temporary license to practice medicine, surgery and midwifery in the State of Michigan by authority of the Michigan State Board of Registration in Medicine.

All active members shall be eligible to vote and hold office, and shall pay such dues and assessments as may be fixed by the House of Delegates.

3. That to make room for a new Section 2 of Chapter 5, the sections presently numbered 2-9 inclusive be numbered 3-10 respectively, and a new Section added as follows:

"Section 2. Non-Licensed Members: Component county societies may elect to membership in this category doctors of medicine who are engaged in teaching, research, or administration, but are not directly concerned with the care of patients, and who do not hold a valid license to practice medicine, surgery and midwifery in Michigan by authority of the Michigan State Board of Registration in Medicine, but comply otherwise with all applicable provisions of these Bylaws. Such members shall be eligible to vote and hold office, and shall pay the same dues as Active Members."

4. That present Section 3(d) of Chapter 5 (new Section 4) be deleted; and be it further

RESOLVED, That the Michigan Delegates to the American Medical Association be instructed to prepare and introduce into the House of Delegates of the AMA a resolution seeking similar amendments to the Constitution and Bylaws of the AMA.

THE SPEAKER: This resolution will be referred to the Reference Committee on Constitution and Bylaws.

X—4. EDUCATION OF REGISTERED NURSES

E. M. VARDON, M.D. [Wayne]:

Whereas, there has been a shortage of nursing personnel for many years, and

Whereas, there will undoubtedly be a far greater demand for nursing personnel of all classifications in the future, and

Whereas, segments of the nursing profession and some universities have apparently placed emphasis on the recruitment and education of degree nurses, and

Whereas, some of the other schools of nursing which graduate registered nurses are having difficulty in obtaining proper cooperation on the part of colleges and universities to educate their students in the basic sciences, and

Whereas, these registered nurses are urgently needed in most of the specialties and in many other situations; therefore, be it

RESOLVED: That equal support be given to all accredited schools of nursing; and be it further

RESOLVED: That the various communities in the State be enlisted to encourage the tax-supported colleges and universities to provide and make available the basic science courses needed in the education of registered nurses.

THE SPEAKER: This will be referred to the Reference Committee on Legislation and Public Relations.

X—5. GOOD SAMARITAN LEGISLATION

WILLIAM J. YOTT, M.D. [Wayne]:

Whereas, a physician when rendering emergency care at the scene of an emergency acts in the role of a Good Samaritan, and

Whereas, a physician should not be subject to civil liability for such an act of mercy, and

Whereas, the Senate of the State of Michigan did pass S. B. 1385 to relieve any physician who in good faith renders such emergency care from civil liability; therefore, be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society strongly recommend to the next session of the Michigan Legislature prompt enactment of S. B. 1385, or similar legislation; and be it further

RESOLVED: That a copy of this resolution be transmitted to each member of the Michigan Legislature elected in the November 1962 State election.

THE SPEAKER: This is referred to the Reference Committee on Legislation and Public Relations.

X—6. A TRIBUTE TO THE MSMS COUNCIL, THE OFFICERS, AND THE LEGAL AFFAIRS COMMITTEE

JACK ROM, M.D. [Wayne]:

Whereas, the years 1961-1962 have been critical in their effect on the future of American medicine, and

Whereas, The Council, the President and the Legal Affairs Committee have guided the destiny of the Michi-

gan State Medical Society in a superb way during this critical period; therefore, be it

RESOLVED: That The Council, the President and the Legal Affairs Committee be accorded the sincere appreciation of the House of Delegates of the Michigan State Medical Society for leadership and stimulation of the membership to help defeat radical legislation in the Congress of the United States inimical to the best interests of the health of the American people.

THE SPEAKER: This is referred to the Reference Committee on Resolutions.

X—7. HEALTH AND PHYSICAL FITNESS OF SCHOOL CHILDREN

ALICE E. PALMER, M.D. [Wayne]:

Whereas, evidence from Selective Service records shows less than adequate health status of youth, and

Whereas, there is need for responsible and well-conceived programs for child health, and

Whereas, the problem of physical fitness has become one of national concern; therefore, be it

RESOLVED: That the House of Delegates urges the component county medical societies, in conjunction with their respective Boards of Education, Departments of Health, community and service organizations to assume leadership in exploring ways in which the health and physical fitness of school children can be promoted and improved.

THE SPEAKER: This is referred to the Reference Committee on Hygiene and Public Health.

X—8. EVALUATION OF NON-HOSPITAL MEDICAL CARE

F. P. RHOADES, M.D. [Wayne]:

Whereas, the medical profession maintains high standards of care in hospitals through the use of audit and tissue committees, and

Whereas, the evaluation of non-hospital medical care is more difficult; therefore, be it

RESOLVED: That the Michigan State Medical Society study possible means for evaluating the medical care of non-hospitalized patients either through an existing committee or by formation of a new special committee.

THE SPEAKER: This will be sent to the Reference Committee on Resolutions.

X—9. DECISION IN APPEAL CASES

L. J. BAILEY, M.D. [Wayne]:

Whereas, Chapter VI of the Michigan State Medical Society Bylaws does not state that The Council shall render a decision on an appeal case within a specified time, and

Whereas, in one appeal case The Council failed to act within a period of one year, and

Whereas, such failure by The Council to act may, and has, negated the disciplinary action recommended by the county medical society; therefore, be it

RESOLVED: That the Committee on Constitution and Bylaws be directed to amend Chapter 6 of the Bylaws to specify that The Council of the Michigan State Medical Society must give a decision on an appeal case within a definite period of time, not longer than ninety days.

THE SPEAKER: This will be referred to the Reference Committee on Constitution and Bylaws.

X—10. REPORTING OF VENEREAL DISEASE

J. R. MONTANTE, M.D. [Wayne]:

Whereas, the diagnosis of disease processes (including venereal disease) is the function of the attending physician of a patient, and

Whereas, laboratory findings are but a part of a complex upon which a physician bases a diagnosis, and in themselves are not diagnostic, and

Whereas, it is the duty of the attending physician to report cases of communicable disease to the health departments, and

Whereas, The Council of the Michigan State Medical Society has gone on record as opposed to the reporting of findings suggestive of venereal disease by pathologists and laboratories directly to the health departments; therefore, be it

RESOLVED: That the House of Delegates request the Commissioner of Health of the State of Michigan to rescind his ruling requiring pathologists and laboratories to report findings suggestive of venereal disease by name and address of patient directly to local and/or state health departments; and be it further

RESOLVED: That, if necessary, legal steps be taken by the Michigan State Medical Society to prevent the Commissioner from enforcing this ruling; and be it further

RESOLVED: That, if necessary, the Michigan State Medical Society initiate and support legislation that will place the responsibility of reporting venereal and other communicable disease on the attending physician and remove any responsibility for such reporting from pathologists and laboratories.

THE SPEAKER: This will be referred to the Reference Committee on Hygiene and Public Health.

X—11. PROPOSED CHANGES IN KERR-MILLS LAW

H. A. FURLONG, M.D. [Oakland]:

Whereas, it is the obvious obligation of the community to provide for the hospital and medical care of individuals who through age, infirmity or misfortune are unable to provide it for themselves, and

Whereas, it is financially impossible for those on a limited income at an age over sixty-five to provide all or partial insurance coverage, and

Whereas, the Kerr-Mills law contains many good features—but also contains some limited features, and

Whereas, appropriate legislation be expanded to fulfill certain limitations of this bill, namely, to

1. provide the best available hospital and medical care;
2. preserve the dignity of the individual;
3. allow choice of hospital and physician and the doctor-patient relationship;
4. entail a minimum of bureaucratic control, and
5. cost the community as little as is consistent with the above, and

Whereas, it is an established policy for local, state or federal government to subsidize privately operated services and activities which are in the public interest, and

Whereas, it is appropriate for organized medicine to propose constructive, progressive and realistic action; therefore, be it

RESOLVED: That the Michigan State Medical Society strongly urge our local, State and Federal Government to change or amend the exiting law to

1. Increase the eligibility of the single person over sixty-five years of age from $1,500 to $2,500 and couples from $2,500 to $4,000;

2. Make the eligibility of a person or persons contingent only on a statement or form from the Internal Revenue Department which will establish their lawful and just eligibility under this law;

3. Make the benefits under such medical and hospital contract be similar to those normally provided for this income group as rated by private carriers;

4. Minimize bureaucratic control over this plan, which would permit every accredited hospital in the community to be set up to establish eligibility of the individual and be empowered to take appropriate steps to dispatch the individual's application to the nearest appropriate governmental agency;

5. To further minimize bureaucratic control, the local, State or Federal Government be instructed to buy insurance through an already existing insurance carrier

for the indigent individual or individuals at a normal sum which will be adequate to cover the best available hospital and medical care for these individuals; and

6. To promote legislation which would permit an individual or individuals who are over sixty-five years of age and who have limited means but exceed the existing financial limits of this law to deduct from his federal income tax or from his local or state tax a sum of monies which would permit him to buy hospital and medical coverage and use the receipt of this health payment as proof for lawful deductions; and it be it further

RESOLVED: That the Michigan State Medical Society believes such legislation would fulfill our stated obligations and fulfill a much-needed improvement in our already existing laws.

THE SPEAKER: This is referred to the Reference Committee on Legislation and Public Relations.

X—12. SURGICAL ASSISTANT'S FEE

J. G. SLEVIN, M.D. [Wayne]:

Whereas, the present practice of Michigan Medical Service, under certain circumstances, is not to allow an assistant's fee even when an adequate number of residents are unavailable to cover the surgical service, and

Whereas, many hospitals do not have a full quota of residents; therefore, be it

RESOLVED: That the House of Delegates recommend to Michigan Medical Service that it pay an assistant's fee when a resident is not available; and be it further

RESOLVED: That such fee be paid only when an assistant is needed and actual assistance is given.

THE SPEAKER: This will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

X—13. MEDIATION COMMITTEES

M. R. WEED, M.D. [Wayne]:

Whereas, Chapter VII of the Bylaws of the Michigan State Medical Society, entitled, "Grievances of Non-members—Mediation Committees," directs each county society to establish a Mediation Committee and specifies policy, purposes, duties and powers of these Committees, and

Whereas, this Chapter is unrelated to any committee or activity of the State Society and concerns the component county societies only, and

Whereas, it is the responsibility of the Michigan State Medical Society to guide and assist but not to direct the activities of the county medical societies, and

Whereas, it is recognized that it is the responsibility of the county society to reconcile these grievances and misunderstandings between physicians and their patients, and

Whereas, each county medical society must have the prerogative of developing and following these procedures most effective in its area for carrying out this responsibility to the public and to the physicians; therefore, be it

RESOLVED: That Chapter VII of the Bylaws require only that county societies make provision for mediation committees in their bylaws; and be it further

RESOLVED: That the procedures under Chapter VII, titled, "Grievances of Non-Members—Mediation Committees," become an appendix to the Bylaws of the Michigan State Medical Society for the guidance of the component county society; and be it further

RESOLVED: That Chapter VII be deleted from the Bylaws.

THE SPEAKER: This will be referred to the Reference Committee on Constitution and Bylaws.

X—14. PROTECTIVE HEALTH MEASURES FOR BOXERS

J. G. SLEVIN, M.D. [Wayne]:

Whereas, ten deaths are reported to have occurred thus far this year among professional boxers as a result of brain damage from head injuries suffered during ring encounters, and

Whereas, in the future such deaths might be prevented by stricter physical examinations and by suspension of any participant who sustains a knockout or other severe injury for as long as medical consultants deem it necessary, and

Whereas, the ringside physician should have authority to terminate the contest at any time for medical reasons, and

Whereas, the medical profession should be and is concerned that in all competitive sports participants should be physically fit and should have adequate medical protection against unnecessary risk of injury; therefore, be it

RESOLVED: That the House of Delegates urge the enactment of laws for the stricter physical examination of both amateur and professional boxers and the granting of authority to the ringside physician to stop a fight at any time he deems it medically advisable; and be it further

RESOLVED: That a copy of this resolution be furnished each member of the Michigan Legislature elected in the November 1962 state election.

THE SPEAKER: This is referred to the Reference Committee on Legislation and Public Relations.

X—15. DISCIPLINARY PROCEDURES

L. F. SEGAR, M.D. [Wayne]:

Whereas, Chapter VI of the Bylaws of the Michigan State Medical Society, titled "Conduct & Discipline of Members," dictates in great detail the procedures the county medical society must follow in disciplining its members, and

Whereas, with the exception of those sections outlining appeal procedures, Chapter VI is unrelated to any committee or activity of the State Society, and

Whereas, the procedures in Chapter VI are long, complicated, technical, and make it difficult to process cases judiciously and expeditiously, which is in the best interest of the physician and the patient; therefore, be it

RESOLVED: That the Committee on Constitution and Bylaws be directed to amend Chapter VI to limit its contents to what comes properly within the scope of the State Society, that is, appeal procedures; and be it further

RESOLVED: That each component medical society be instructed to include in its bylaws equitable procedures to carry out its responsibilities for the conduct and discipline of its members.

THE SPEAKER: This is referred to the Reference Committee on Constitution and Bylaws.

X—16. SINGLE MEDICAL PRACTICE ACT

F. C. RYAN, M.D. [Kalamazoo]:

Whereas, the Medical Socio-Economic Committee has given serious consideration and deliberation to the House of Delegates recommendation regarding a single Medical Practice Act for Michigan, and

Whereas, the previous action of the 1961 House of Delegates does not clearly define "a single Medical Practice Act"; therefore, be it

RESOLVED: That this matter be re-studied and clarified.

THE SPEAKER: This is referred to the Reference Committee on Legislation and Public Relations.

X—17. MICHIGAN RELATIVE VALUE SCALE

N. L. AVERY, M.D. [Kent]:

Whereas, the 1957 House of Delegates authorized the development of the Michigan Relative Value Scale; A Relative Value Study Committee, after three years of work, presented to the September 1961 House of Delegates its final report, and

Whereas, the 1961 House of Delegates instructed the Speaker to appoint a committee of the House of Dele-

gates to take every possible means to determine that this Relative Value Study Report is thoroughly understood by every member, and

Whereas, the Report of the Relative Value Study Committee was distributed to the membership of the Michigan State Medical Society for the purpose of information and with request for opinions, questions and observations, and

Whereas, to date no official action has been taken by the House of Delegates regarding this report; therefore, be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society approve the final report of the Relative Value Study Committee as submitted to the House of Delegates in September 1961; and be it further

RESOLVED: That this action of the House be referred to the Board of Trustees of Michigan Medical Service for implementation as soon as it is practicable.

THE SPEAKER: This will go to the Reference Committee on Special Committees.

X—18. INCLUDING DOCTORS OF MEDICINE IN OLD AGE SURVIVAL INSURANCE

J. R. PEDDEN, M.D. [Kent]:

Whereas, the most recent poll on the inclusion of physicians in the Old Age Survival Insurance taken by the Michigan State Medical Society was obscuring, confusing, and failed to give a clear-cut directive, and

Whereas, the question of the inclusion of the medical profession in Old Age Survival Insurance is a measure of grave concern to physicians and also of extreme importance to their public relations in the nation, and

Whereas, many physicians are already under Old Age Survival Insurance; therefore, be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society favor the inclusion of the doctors of medicine in Old Age Survival Insurance and to instruct its delegates to the American Medical Association to implement this decision.

THE SPEAKER: This is referred to the Reference Committee on Resolutions.

X—19. FUNCTION OF PUBLIC HEALTH SERVICE

FRANK S. PERKIN, M.D. [Wayne]:

Whereas, the function of the Public Health Services, national, state, county and local, is the control of contagious diseases, the protection of the public against communicable diseases by various means, the compilation of vital statistics, the provision of public health education and information, the investigation of the spread of disease and the suppression of epidemics, and

Whereas, treatment of such diseases as diabetes, cardiovascular disease, malignancy, and mental illness do not fall within the purview of the Public Health Service, and

Whereas, these diseases are not communicable or contagious; therefore, be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society strongly condemns the encroachment of Public Health Service into those fields of medicine especially mentioned or any field of medicine not specifically and directly the concern of such Public Health Service as being contrary to the best interests of the public.

THE SPEAKER: This is referred to the Reference Committee on Legislation and Public Relations.

X—20. SINGLE MEDICAL PRACTICE ACT

HOMER A. HOWES, M.D. [Wayne]:

Whereas, a single medical practice act for M.D. and D.O. registration in Michigan would provide the citizens of Michigan with a single standard for the practice of the healing arts, and

Whereas, such an act has been advocated in the McNerney Report to safeguard the public, and

Whereas, the Michigan State Medical Society did urge upon the Legislature of Michigan at its 1961 Session the adoption of such an act only to have the bill die in the Legislature; therefore, be it

RESOLVED: That the House of Delegates reaffirm its endorsement of a single medical practice act for registration of M.D.s and D.O.s; and be it further

RESOLVED: That The Council of the Michigan State Medical Society be instructed to take the necessary steps to have such legislation reintroduced at the next session of the Legislature; and be it further

RESOLVED: That a copy of this resolution be transmitted to each member of the Michigan Legislature elected in November 1962 and to the Michigan Osteopathic Association of Physicians and Surgeons.

THE SPEAKER: This will go to the Reference Committee on Legislation and Public Relations.

X—21. COMMENDATION TO AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS

R. K. WHITELEY, M.D. [Wayne]:

Whereas, the American Association of Medical Assistants is having their Sixth Annual Meeting in Detroit, September 1962, and

Whereas, they are composed of employees of doctors of medicine, and

Whereas, they have a formal in-service training program and the organization is growing at a rapid pace; therefore, be it

RESOLVED: That the Michigan State Medical Society commend them for their increasing knowledge, training, and valuable assistance; and be it further

RESOLVED: That the official greetings of the Michigan State Medical Society be extended to them; and be it further

RESOLVED: That a copy of this resolution be sent to the American Association of Medical Assistants.

THE SPEAKER: This is referred to the Reference Committee on Resolutions.

X—22. CHANGE IN THE DUTIES OF THE MSMS SECRETARY AND THE EXECUTIVE DIRECTOR

L. J. BAILEY, M.D. [Wayne]:

Whereas, the Bylaws now delegate to the Secretary duties which are in practice conducted by the Executive Director, and

Whereas, these duties properly fall within the province of the Executive Director; therefore, be it

RESOLVED: That Chapter 12, Section 6 be amended to delete sentence 2: "He shall be paid a salary to be determined by The Council," and to delete sentence 4: "He shall be bonded in amount considered sufficient by The Council, the cost of which shall be paid from the funds of the Society"; and be it further

RESOLVED: That Chapter 12, Section 7 be amended to add to paragraph 1: "He shall be bonded in amount considered sufficient by The Council, the cost of which shall be paid from the funds of the Society"; to delete paragraph 2 and add: "Any or all of the duties assigned to the Secretary in these Bylaws may be delegated by The Council to the Executive Director."

THE SPEAKER: Resolution No. 22 will also be referred to the Reference Committee on Constitution and Bylaws.

X—23. CORRECTION IN NUMBER OF NEW MSMS COUNCILORS

F. P. RHOADES, M.D. [Wayne]:

Whereas, with the change in Councilor term from five years to three years, only three Councilors will be elected in 1962 and nine will be elected in 1963, and

Whereas, this inequality in numbers of new Councilors might result in too radical a change in personnel in certain years; therefore, be it

RESOLVED: That Section 1, Chapter 12 of the Bylaws be amended to read as follows:

"Section 1 - TERMS OF OFFICE—Except as herein otherwise provided, officers shall take office immediately after the election. With the exception of Councilors, they shall serve until the next Annual Session and until their respective successors shall have been elected. Councilors elected prior to 1960 shall serve for five years. Councilors elected in 1960 and thereafter shall serve for three years, provided, however, that in the year 1963 six Councilors shall be elected for terms of three years each and three Councilors shall be elected for terms of two years each. The election of Councilors in said years shall be conducted in the usual manner as prescribed in Section 10 or Chapter 9 of these Bylaws, and immediately thereafter, the length of the respective terms to be served by those elected shall be determined by lot under the direction of the Speaker of the House of Delegates."

THE SPEAKER: This will be referred to the Reference Committee on Constitution and Bylaws.

X—24. CHANGE IN THE DUTIES OF THE MSMS SECRETARY AND EXECUTIVE DIRECTOR

L. J. BAILEY, M.D. [Wayne]:

Whereas, the Bylaws now delegate to the Secretary duties which are in practice conducted by the Executive Director, and

Whereas, these duties properly fall within the province of the Executive Director; therefore, be it

RESOLVED: That Chapter 12, Sections 6 and 7 of the Bylaws be amended as follows:

"Section 6 - SECRETARY—The Secretary shall be an active member of the Society. He shall be the recording officer of the Scientific Assembly and the Annual Session. He shall perform those duties ordinarily devolving on a secretary of a corporation by law as assigned by the House of Delegates and/or The Council and such duties as are specifically assigned in these Bylaws."

"Section 7 - EXECUTIVE DIRECTOR—There shall be an Executive Director, not necessarily a doctor of medicine or a member of the Society, who shall be appointed by and responsible directly to The Council. He shall be remunerated by a salary which shall be fixed by The Council. He shall be bonded in amount considered sufficient by The Council, the cost of which shall be paid from the funds of the Society. He shall be the recording officer of the House and Delegates and of The Council. He shall discharge the following duties: (a) Collect all annual membership dues, assessments, donations, and such other monies as may be due to the Society; keep membership records and issue membership certificates.

"(b) He shall make all required reports to the American Medical Association. He shall make such reports of the proceedings of the House of Delegates as may be required of him.

"(c) He shall deposit all funds received in an approved depository and disburse them upon order of The Council. The Council may delegate the authority for disbursing funds to the Executive Committee of The Council. The Council shall cause an annual audit of his accounts to be made by a certified public accountant. He shall render a report to The Council reviewing the Society's activities and imparting recommendations for the advancement of the Society's interests at each meeting of The Council.

"(d) Under the direction of The Council and with the advice of the Editor, he shall be the business manager of THE JOURNAL of the Michigan State Medical Society.

"(e) He shall superintend all arrangements for the holding of each meeting in compliance with the Constitution and Bylaws and instructions of The Council or its Executive Committee.

"(f) He shall send out all official notices of meetings, committee appointments, certificates of election to office and special committee assignments.

"(g) He shall receive and transmit to the House of Delegates and to The Council the Annual and other reports of Officers and committees.

"(h) He shall institute and correlate each new activity of the Society under the supervision of The Council or its Executive Committee. He shall assist in component county society integration and furnish information to the public concerning health matters as directed by the President and The Council.

"(i) He shall perform such other duties as may be assigned by The Council."

". . . and be it further

"RESOLVED: That the following Sections in the Chapters indicated be amended by changing the word 'Secretary' to 'Executive Director':

"Chapter 4—Section 3;

"Chapter 5—Sections 2, 3, 5;

"Chapter 9—Sections 3, 10, 13;

and be it further

"RESOLVED: That Chapter 6, Section 14 be amended in sentence 2 to read: 'The notice shall be served on The Council of the Michigan State Medical Society and on the appellant's component county society by registered or certified mail, addressed to the Executive Director of the Michigan State Medical Society and the secretary of the component county society respectively'; and be it further

"RESOLVED: That Chapter 9, Section 5 be amended to delete sentence 2, viz.: 'The Secretary of the Society shall be the Secretary of the House of Delegates.'"

THE SPEAKER: Resolution No. 24 will be referred to the Reference Committee on Constitution and Bylaws.

X—25. IMMUNITY FROM LEGAL ENTANGLEMENTS WHEN DRAWING BLOOD SAMPLES

PAUL IVKOVICH, M.D. [Mecosta-Osceola-Lake]:

Whereas: the medical profession believes that physicians cannot take blood samples at the request or order from law enforcing officers to determine the alcoholic content without being exposed to certain legal entanglements and contents; therefore, be it

RESOLVED: That the Mecosta-Osceola-Lake County Medical Society petition the Michigan State Medical Society through its delegate and that other county medical societies do likewise; to ask the State Legislature for adequate legislation so that doctors may take blood samples to determine alcoholic content with complete immunity from all legal entanglements and consequences.

The above resolution, we believe, is in accordance with the principles pertaining to the health and safety of the citizens of the State of Michigan.

THE SPEAKER: This will be considered as Resolution No. 25 and will be referred to the Reference Committee on Legislation and Public Relations.

X—26. PROPOSED INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

W. C. C. COLE, JR., M.D. [Wayne]:

Whereas, the Federal Government has been asked to establish an Institute of Child Health and Human Development in H.R. 11099, and

Whereas, this Institute is unnecessary because it duplicates current activity by voluntary interests and represents an additional attempt for intervention by the Federal Government in the lives of the citizens of the country; therefore, be it

RESOLVED: That the Michigan State Medical Society urge the American Medical Association to oppose the enactment of H.R. 11099 and any similar legislation directed toward the same purpose.

THE SPEAKER: This will be referred to the Reference Committee on Legislation and Public Relations.

X—27. USE OF MICHIGAN RELATIVE VALUE SCALE

R. V. Taylor, M.D. [Jackson]:

Whereas, the Michigan State Medical Society has determined a Relative Value Index of physicians' services, and

Whereas, the Michigan Relative Value Scale is a fair and equitable mechanism for the basis of contractural negotiations for medical services on the part of the Michigan State Medical Society; therefore, be it

RESOLVED: That the Michigan Relative Value Scale be approved as the basis for negotiating the fee schedule with all governmental agencies, etc.; and be it further

RESOLVED: That Michigan Medical Service be requested to use the Michigan Relative Value Scale in any and all contracts which the Michigan State Medical Society is expected to implement on a *service* basis.

The Speaker: That will be referred to the Reference Committee on Special Committees.

X—28. ENDORSEMENT OF H.B. 39, 1962 REGULAR SESSION, MICHIGAN STATE LEGISLATURE

D. D. Finlayson, M.D. [Chippewa-Mackinac]:

Whereas, both Houses of the Michigan Legislature, during the 1962 Regular Session, passed and presented to the Governor House Bill No. 39, providing that the Legislature review and approve administrative rules of state agencies before such rules might become effective, and

Whereas, administrative rules have the force and effect of law, and, while they must properly be administered by the several agencies, their authorization should be the duty of those elected by and responsible to the people; therefore, be it

RESOLVED: That the Michigan State Medical Society commends the State Legislature on its action in presenting this Act to the Governor and urges that, inasmuch as it did not become law by reason of executive veto, it be reintroduced and again passed by the 1963 Legislature and enacted into law; and be it further

RESOLVED: That this House of Delegates urge that the Governor of Michigan, by signing such a bill into law, assure legislation by properly enacted statute rather than by administrative fiat.

The Speaker: That will be referred to the Reference Committee on Legislation and Public Relations.

X—29. CHANGE IN ADMINISTRATIVE RULES OF MICHIGAN MEDICAL AID TO THE AGED ACT

D. D. Finlayson, M.D. [Chippewa-Mackinac]:

Whereas, the Michigan State Social Welfare Commission has administratively ruled that payments for hospital and medical services rendered under the Michigan Medical Aid to the Aged (MAA) program cannot exceed those made for similar services furnished to welfare or other governmental patients, and

Whereas, the MAA program is specifically designed to assist those aged persons who are self-sufficient but whose assets and income are insufficient to defray the added expense of serious illness, and

Whereas, aged persons qualified for MAA are therefore not always indigent, and the Congress and the Michigan Legislature intend that they receive the services of the physicians and hospitals of their own choice, and

Whereas, the administrative ruling results in reimbursement to hospitals and physicians for their medical care at levels less than or comparable to welfare patients in other areas of Michigan, and

Whereas, such reimbursement levels often work such a financial hardship upon private hospitals that these non-indigent aged are forced to accept hospitalization in public facilities where they cannot be cared for by their own physicians, and

Whereas, this situation adversely affects the free choice of physician and hospital by the patient and therefore destroys the physician-patient relationship so vital to expeditious healing; therefore, be it

RESOLVED: That the Michigan State Medical Society urge the Michigan State Social Welfare Commission to abolish this administrative rule and to direct that all payments for hospital service and medical care for MAA recipients be the fair and average fee for such services.

The Speaker: This will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

X—30. HEALTH INSURANCE POOLING

K. S. Wenner, M.D. [Calhoun]:

Whereas, successful plans have been developed and are now in operation in Connecticut, Massachusetts and New York State, and are under consideration elsewhere, to provide for the "pooling" of high risk groups covered by health insurance, thus making possible the offering of coverages of greater adequacy at less cost to subscribers of such high risk groups, and

Whereas, the concept of "risk pooling" has long proven sound in application to automobile insurance and, where now in operation in the health insurance field, has proven of great value to the elderly and others, and

Whereas, it is necessary for the Michigan statutes to be changed so as to permit private, voluntary health insurance companies in this State to adopt similar programs; therefore, be it

RESOLVED: That the Michigan State Legislature is herewith urged to enact suitable enabling legislation permitting the creation of health insurance pooling plans, and the health insurance companies acting through the Health Insurance Institute are urged to speedily explore the implementation of such plans.

The Speaker: That will be referred to the Reference Committee on Legislation and Public Relations.

X—31. GET OUT THE VOTE

K. S. Wenner, M.D. [Calhoun]:

Whereas, the medical profession has always been acutely aware of the importance of exercising the franchise to vote in the pattern of good citizenship, and has consistently urged its members and their families to faithfully vote in all elections and encourage all with whom they come in contact to do likewise, and

Whereas, on November 6, 1962 the State of Michigan will hold a particularly important election, all congressional, State and local offices being on the ballot, and

Whereas, in these times the opportunity of Americans to participate in free elections holds up to the world a great example, and every qualified voter should take advantage of his priceless heritage of freedom to select those who will create the laws under which we are to be governed; therefore, be it

RESOLVED: That this House of Delegates again urge every Michigan physician, his wife and family to participate in the November 6 election, and to urge everyone with whom they come in contact to do likewise; and be it further

RESOLVED: That the Michigan medical profession pledge itself to assist, wherever and whenever possible, the ill, disabled and shut-in to obtain absentee ballots so that they will not be denied their rights, privilege and responsibility to vote.

The Speaker: That will be referred to the Reference Committee on Resolutions.

X—32. SOCIAL SECURITY TAXES

ALEXANDER BLAIN III, M.D. [Wayne]:

Whereas, there is presently no upper limit to the amount of Social Security taxes which may be imposed upon the people of the United States by the Federal Government, and

Whereas, since the inception of the Social Security program expansions in same have been accompanied by an ever-increasing tax level, and there are presently scheduled additional raises in the Social Security tax which will, without further benefit to the people under the program, result in more than 9 per cent of the low wage earner's salary going to Social Security taxes within another six years, and

Whereas, taxes of all types, federal, state and local are increasing at such a rapid rate as to impose a definite hardship upon those of medium or low income; therefore, be it

RESOLVED: That this House of Delegates support House Joint Resolution No. 673 in the current Congress as introduced by Representative Hurlong, to limit the amount of Social Security tax which may be imposed; and be it further

RESOLVED: That a copy of this resolution be transmitted to Representative Hurlong and to the Michigan delegation in the Congress.

THE SPEAKER: This will be referred to the Reference Committee on Legislation and Public Relations.

X—33. JOINT ACCREDITATION COMMITTEE POLICY

H. A. SCOVILL, M.D. [Washtenaw]:

Whereas, under the Joint Hospital Accreditation ruling it is not permissible to substitute scientific, departmental or section programs that are currently not associated with the work of the hospital, and

Whereas, this precludes the possibility of having eminent authorities from the various fields of medicine discuss recent studies, findings, and current trends that would be educational and beneficial to physicians, total staffs and patients, and

Whereas, the policy of the Joint Accreditation Committee thus hampers the dissemination and acquisition of recent knowledge; therefore, be it

RESOLVED: That the Cardiac Disease Control Committee respectfully request the House of Delegates of the Michigan State Medical Society to present a similar resolution to the House of Delegates of the American Medical Association for prompt, definitive action in order to facilitate alteration of the present ruling.

THE SPEAKER: That will be referred to the Reference Committee on Miscellaneous Business.

X—34. INTERNAL REVENUE MECHANISMS

H. A. SCOVILL, M.D. [Washtenaw]:

Whereas, H.R. 9387, introduced in the Congress by Representative Johansen of Michigan, would amend the Internal Revenue Code to provide a credit against the individual income tax for certain amounts paid as premiums on account of medical care insurance for individuals 65 years of age and over, and

Whereas, enactment of this Federal law would substantially benefit American wage earners who maintain medical care insurance coverage at or after age 65 and would also markedly benefit younger wage earners who assist those above age 65 in maintaining voluntary insurance coverage through granting of income tax credits, and

Whereas, H.R. 9387 encourages the growth and development of private, voluntary medical care insurance coverage, encourages responsibility on the part of Americans in behalf of their elders, and recognizes that a significant portion of the costs of such coverage can be rebated through an already existing Federal Government mechanism, and

Whereas, the adoption of the Internal Revenue Code as a means to encourage adequate medical care insurance coverage for the elderly is superior to the adoption of the Social Security mechanism which would require both increased taxes to be levied on workers and the creation of new Federal agencies; therefore, be it

RESOLVED: That this House of Delegates endorse H.R. 9387 and urge the Congress of the United States to enact the same; and be it further

RESOLVED: That a copy of this resolution be transmitted to the Congress and the President of the United States.

THE SPEAKER: This will be referred to the Reference Committee on Legislation and Public Relations.

X—35. URGING PASSAGE OF THE CURTIS BILL

H. A. SCOVILL, M.D. [Washtenaw]:

Whereas, the 1961 House of Delegates of the Michigan State Medical Society adopted Resolution No. 39 urging the development of plans whereby funds might voluntarily be set aside by plan participants during their productive years for the purpose of assuring medical care during their retirement years, and

Whereas, H.R. 10117 (the Curtis Bill) in the 1962 Congress incorporates this basic principle endorsed in 1961 by MSMS, by providing a tax incentive for employers to incude health care in employee retirement programs so that individuals (through fringe benefits) may finance health insurance during their working years to cover future health needs, and

Whereas, the U. S. House of Representatives has passed H.R. 10117; therefore, be it

RESOLVED: That the Michigan State Medical Society commend Congressman Curtis for introducing, and the House of Representatives for passing, this bill which can provide another meaningful step in providing for the health needs of retired Americans through the voluntary system; and be it further

RESOLVED: That MSMS urge the U. S. Senate to enact and the President of the United States to sign into law H.R. 10117; and be it further

RESOLVED: That this House of Delegates urge Michigan Medical Service and Michigan Hospital Service, as well as the private health insurance companies acting through the Health Insurance Institute, to speedily develop and implement programs which will enable American workers, pensioners and employers to realize the benefits of H.R. 10117.

THE SPEAKER: This will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

X—36. EXTENDING GOOD SAMARITAN LEGISLATION TO COVER HOSTILE ATTACK OR DISASTER

F. H. POWER, M.D. [Grand Traverse-Leelanau-Benzie]:

Whereas, there is nation-wide interest in the problem of relieving physicians and paramedical personnel of liability to subsequent malpractice action, based on professional services rendered under emergency conditions, and

Whereas, in event of attack on this country by a hostile power, or in event of a widespread disaster, medical personnel will be required to make medical decisions affecting the lives and future well-being of hundreds of injured persons, which decisions in the light of subsequent civil court actions might be difficult to defend, and

Whereas, other states have deemed it wise to specifically relieve physicians from subsequent civil court malpractice actions resulting from such catastrophic circumstances, and

Whereas, in the opinion of our Attorney General's Office our Civil Defense Protection Act does not clearly provide immunity from subsequent civil action for medical services rendered in time of attack or disaster, and

Whereas, S. B. 1385 as recently passed by the Senate does not specifically include this type of immunity; therefore, be it

RESOLVED: That this House of Delegates direct the Committee on Legal Affairs to strongly urge the Legislature to add appropriate immunity from subsequent malpractice action for medical personnel who are required to render their professional services under adverse conditions created by enemy attack or severe natural disaster.

THE SPEAKER: This will be referred to the Reference Committee on Legislation and Public Relations.

X—37. BLUE CROSS COVERAGE FOR MSMS WIDOWS AND FAMILIES

F. H. POWER, M.D. [Grand Traverse-Leelanau-Benzie]:

Whereas, widows of physicians are ordinarily extended professional courtesy by our colleagues, and hence in the field of medical care insurance are most in need of adequate hospital care coverage, particularly in their advancing years, and

Whereas, despite the fact that MSMS fathered Blue Cross in Michigan, the widows of physicians whose families were covered under the MSMS contract with Blue Cross are dropped from that contract, and are transferred to a group conversion contract at a 13 per cent higher premium for 120 days of coverage, and are denied the privilege of continuing the rider providing for an additional 245 days' coverage which they had under the MSMS contract, and

Whereas, the Committee on Professional Insurance Plans (as reported in item 5 of its annual report) has investigated the matter as it applies to Blue Shield only, and has concluded that currently widows of physicians cannot qualify for continued participation in the MSMS Blue Shield contract, and

Whereas, the Bylaws of MSMS and its component county societies provide special membership for certain persons who are not doctors of medicine, but for whom membership in the Society would be beneficial to both parties concerned; therefore, be it

RESOLVED: That the Committtee on Professional Insurance be instructed to restudy the problem of providing continuing hospital insurance coverage to the widows of MSMS members under the MSMS Blue Cross contract, possibly recommending a special membership classification in MSMS and component societies for members of the Auxiliary.

THE SPEAKER: This will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

X—38. COMMENDATION TO LAWRENCE A. DROLETT, M.D.

R. M. STOW, M.D. [Ingham]:

Whereas, Lawrence A. Drolett, M.D., has served as the Chairman of the Legal Affairs Committee of the Michigan State Medical Society continuously for fifteen years from 1947 to 1962, and

Whereas, year in and year out this Committee in discharging its responsibility to the physicians of Michigan and to the citizens which they serve, has been required to spend long and arduous hours in reviewing hundreds of complex legislative proposals so as to assure that no legislative proposals inimical to the best health interests of citizens of Michigan be enacted into law, and

Whereas, Dr. Lawrence A. Drolett's dedicated service as Chairman of this Committee has been an inspiration to the scores of men who have served with him, and his leadership and acumen have proved of immeasurable value to the Society which he has served so long and with such distinction; therefore, be it

RESOLVED: That this House of Delegates, on behalf of the entire membership of the Michigan State Medical Society, warmly commends Dr. Lawrence A. Drolett for his outstanding service, and expresses its appreciation and gratitude for the same; and be it further

RESOLVED: That Dr. Drolett be presented with a suitably illuminated and framed copy of this resolution.

THE SPEAKER: This will be referred to the Reference Committee on Miscellaneous Business.

X—39. RECOMMENDING MEMBERSHIP IN THE MICHIGAN ASSOCIATION OF THE PROFESSIONS TO THE MICHIGAN STATE MEDICAL SOCIETY MEMBERSHIP

A. B. GWINN, M.D. [Barry]:

Whereas, the Michigan Association of the Professions has now been existing and functioning for nearly four years, and

Whereas, it has demonstrated that it is fulfilling a need of implementing and coordinating the functions of the various professions to achieve desirable social objectives, and

Whereas, the Michigan State Medical Society was a prime mover in its organization and has found that the policies and programs of MAP are in keeping with, and do advantage, the profession of medicine in Michigan, and

Whereas, only 17 per cent of the members of the Michigan State Medical Society are MAP members compared to a membership of 27 per cent of the Michigan Society of Professional Engineers, 23 per cent of the Michigan Society of Architects, 23 per cent of the Michigan State Dental Association, 19 per cent of the Michigan Veterinary Medical Association, etc., and

Whereas, the MSMS Public Relations Committee, supported by The Council, has repeatedly urged that MSMS members support this organization with their membership; therefore, be it

RESOLVED: That the House of Delegates of the Michigan State Medical Society recommend to all the members of MSMS that they join the Michigan Association of the Professions and actively participate in and support its programs.

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

X—40. PHYSICIAN MEMBERSHIP ON HOSPITAL GOVERNING BOARDS

W. J. DINNEN, M.D. [St. Clair]:

Whereas, the governing boards of the hospitals of the State of Michigan do not uniformly have one or more physicians as permanent voting members to represent and interpret the position of the medical and surgical practice in the affairs of the hospitals; therefore, be it

RESOLVED: That all hospital governing boards be requested to have at least one physician as a permanent voting member of the board, and that at least one physician be a permanent voting member of the executive committee of the board, and that the physician or physicians serving on the board be members of the active medical staff of the hospital and be nominated by the medical staff of the hospital.

THE SPEAKER: This will be referred to the Reference Committee on Miscellaneous Business.

X—41. COUNTY MEDICAL SOCIETY NOMINATIONS TO MSMS COMMITTEES

JAMES H. TISDEL, M.D. [St. Clair]:

Whereas, existing threats to the private practice of medicine in the county and in the State make necessary

the work of aggressive and active committees of our State Society, and

Whereas, the success of these committees depends upon its composition of active, experienced and willing members, and

Whereas, it is becoming increasingly more difficult for the officers of the State Society to know and recognize the qualifications and willingness of the individual members to actively pursue the purposes of the various committees; therefore, be it

RESOLVED: That the officers of the component county medical societies be polled each year for advice concerning nominations to the various State Medical Society committees.

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

X—42. IMPLEMENTATION OF THE KERR-MILLS ACT

E. J. TALLANT, M.D. [Wayne]:

Whereas, the purpose of the Kerr-Mills Act was to furnish medical assistance to the aged and not to provide care for welfare cases, and

Whereas, the Michigan Medical Assistance for the Aged program is administered by the Department of Social Welfare through the Bureau of Social Aid in each county, and

Whereas, the regulations of the Michigan Department of Social Welfare in effect nullify the intent of the Kerr-Mills Act, and

Whereas, if properly administered, the Medical Assistance Program would be beneficial to the public; therefore, be it

RESOLVED: That the administration of the Michigan Medical Assistance Program be completely free and independent of the rules and regulations and policies of the Department of Social Welfare; and be it further

RESOLVED: That the State Legislature be requested to enact appropriate regulations to fulfill the intent of this resolution; and be it further

RESOLVED: That copies of this resolution be sent to each member of the Michigan Legislature.

THE SPEAKER: This is referred to the Reference Committee on Medical Service and Prepayment Insurance.

X—43. CASH RETURN FROM SOCIAL SECURITY

E. J. TALLANT, M.D. [Wayne]:

Whereas, the Social Security program of the Federal Government has always been a program through which Americans have been returned dollars, upon attainment of qualifying age, with which they could purchase those things which they deemed necessary, and

Whereas, the medical profession reaffirms its endorsement of Social Security as a mechanism for the providing of cash benefits and expresses its belief in the ability of Americans to spend their money prudently, and its fundamental faith in the American doctrine of self-determination, and

Whereas, any change in the basic principle of Social Security which would substitute service benefits under the program for cash benefits would tend to create a precedent leading to a government which would be the master rather than the servant of the people, by directing what they must have and must do, regardless of their personal circumstances or desires; therefore, be it

RESOLVED: That the Michigan State Medical Society hereby expresses its unalterable opposition to the substituting of services for cash benefits under the Social Security program, and endorses the continuance of the Social Security program as it was originally intended to operate and has operated.

THE SPEAKER: This will be referred to the Reference Committee on Legislation and Public Relations.

X—44. FAVORING RECOGNITION OF GENERAL HOSPITALS OF REALISTIC SIZE

KENNETH H. JOHNSON, M.D. [Delegate-at-Large]:

Whereas, the Governor's Commission on Prepaid Hospital and Medical Care Plans has recommended that the minimum acceptable size for acute general hospitals should be set at fifty beds, and

Whereas, such a restriction on acceptable size would be particularly unrealistic and grossly discriminate against the citizens of smaller communities who desire to support general hospitals of more realistic size; therefore, be it

RESOLVED: That the Michigan State Medical Society herewith expresses its strong opposition to this recommendation No. 12 of the Governor's Commission, and that this opposition be transmitted to the proper authorities.

THE SPEAKER: This will be referred to the Reference Committee on Legislation and Public Relations.

X—45. CHANGES IN FOOTBALL HEADGEAR

G. A. DRAKE, M.D. [Northern Michigan]:

Whereas, the 1961 football season saw a marked increase in football injuries, the majority of which were to the head and neck, and

Whereas, the design of the present widely used football helmet is characterized by:

1. A projecting face mask (which can serve as a lever or handle by which force is exerted on the cervical spine).
2. A non-resilient exterior shell.
3. A sharp occipito-cervical ridge (which can cause a sharply localized pressure on the cervical spine when the face mask is forced upward), and
4. A strong chin strap (which will not release when the face mask is forced upward), and

Whereas, these characteristics predispose the wearer and his opponent to serious injury, and

Whereas, a well-documented paper appeared in the August 12, 1961 JOURNAL of the American Medical Association by Richard Schneider, M.D., et al, of the Neurosurgical Department at the University of Michigan, illustrating the dangers inherent in the helmet and face mask, and

Whereas, H. O. Crisler, Director of Athletics at the University of Michigan, advises removal of the face mask, with the statement, "If the mask is to be worn, we had better quit playing the game," and

Whereas, Clarence Munn, Director of Athletics at Michigan State University, favors removal of the mask "until something better and safer is produced," and

Whereas, Woody Hayes, head football coach at Ohio State University, has developed a combination rubber and plastic strip 3/8" thick and 4" wide, which covers the crown of the helmet from front to back, and which provides a protective resilience for both the wearer and his opponent, and

Whereas, an informed and actively interested medical profession can do much to insure the adoption of protective measures for athletes; therefore, be it

RESOLVED: That the Michigan State Medical Society strongly urge the appropriate professional, collegiate, primary and secondary school officials in this State to immediately remove face masks, except in the presence of an existing facial injury and before the start of the 1963 football season, apply a resilient strip to the crown of all helmets, according to the specifications at Ohio State University, and also before the 1963 season apply a protective pad to the sharp occipital margin of the helmet.

THE SPEAKER: This will be referred to the Reference Committee on Hygiene and Public Health.

X—46. PSYCHIATRISTS ON MENTAL HEALTH COMMISSION

G. H. Bauer, M.D. [Washtenaw]:

Whereas, the Michigan State Mental Health Department is governed by a Commission consisting of five members appointed by the Governor with the advice and consent of the State Senate, and

Whereas, the Michigan statute does not require that any members of this Commission be practitioners of psychiatry, and

Whereas, the Michigan State Medical Society believes that it would be to the clear advantage of both the Department of Mental Health and the people of Michigan if there were at the top policy level of this Department qualified experts in the field of psychiatry; therefore, be it

RESOLVED: That the Michigan Legislature be requested to amend the law to require that no less than two of the five members of the State Mental Health Commission be qualified psychiatrists.

The Speaker: This will be referred to the Reference Committee on Legislation and Public Relations.

X—47. OPPOSING COMPULSORY RETIREMENT BY REASON OF AGE ALONE

G. H. Bauer, M.D. [Washtenaw]:

Whereas, advances in medical science have contributed to the ever-increasing life expectancy of American citizens, and

Whereas, the pattern of compulsory retirement at age 65 was developed a number of years ago, and

Whereas, the science of gerontology shows that the productive capacities of individuals are not necessarily limited by chronological age alone, and

Whereas, the physicians of Michigan, who are in large measure responsible for the increased years of our citizenry, believe that these years should be happy, healthy and productive ones whenever possible; therefore, be it

RESOLVED: That the House of Delegates hereby express its opposition to mandatory retirement at age 65 solely for reasons of age.

The Speaker: This will be referred to the Reference Committee on Miscellaneous Business.

X—48. DISASSOCIATION OF BLUE SHIELD FROM BLUE CROSS IN PUBLIC UTTERANCES

Paul T. Lahti, M.D. [Oakland]:

Whereas, it is apparent that the public is not aware of the difference between Blue Cross-Michigan Hospital Service and Blue Shield-Michigan Medical Service, and

Whereas, the major portion of the premium and the cost is for Blue Cross and not for Blue Shield, and

Whereas, the greater percentage of most recent rate increases is for Blue Cross and not for Blue Shield, and

Whereas, the doctor is being blamed by the public for these costs and rate increases; therefore, be it

RESOLVED: That Michigan State Medical Society adopt the policy that the doctor be disassociated from Blue Cross in the dissemination of all information to the public; and be it further

RESOLVED: That the Michigan State Medical Society investigate the possibility of using the name MICHIGAN DOCTORS SERVICE in public utterances instead of Blue Shield or Michigan Medical Service; and be it further

RESOLVED: That Michigan Medical Service be urged to implement this policy.

The Speaker: This will be referred to the Reference Committee on Resolutions.

X—49. PERIODIC READJUSTMENT OF UNIT VALUE OF RELATIVE VALUE SCALE

Paul T. Lahti, M.D. [Oakland]:

Whereas, physicians rightfully are opposed to fixed fee schedules which are established and used by third parties such as government, labor and insurance actuaries since they can only result eventually in deterioration of medical care and control by outside parties, and

Whereas, the Relative Value Scale (such as Michigan Blue Shield is committed to) is a fixed fee schedule only if the value of a unit is fixed, and

Whereas, the precedent of a fixed fee schedule must not continue if Blue Shield is to remain a service plan and if Blue Shield expects continued participation by over 50 per cent of Michigan physicians; therefore, be it

RESOLVED: That Michigan Blue Shield be directed to provide readjustment at least every three years of the unit value of the Relative Value Scale in response to (1) the changing cost of living and (2) changes in the average fees charged outside of the plan.

The Speaker: This will be referred to the Reference Committee on Special Committees.

X—50. OPPOSING HEALTH CARE ADVISORY COMMITTEE TO THE STATE INSURANCE COMMISSIONER

Kenneth H. Johnson, M.D. [Delegate-at-Large]:

Whereas, the Governor's Commission on Prepaid Hospital Care Plans has recommended that a seven-man Advisory Council be created for the purpose of advising the Michigan State Insurance Commissioner, and

Whereas, the Commission suggests that, among other things, such an Advisory Council should assist the State Insurance Commission in inquiring into the quality of health care, and

Whereas, this inquiry into the quality of health care has not been, is not now, and should not be properly within the jurisdiction of the Insurance Commissioner, and is in fact the purview of other State agencies, and

Whereas, such an Advisory Council is in fact both undesirable and unnecessary; therefore, be it

RESOLVED: That the House of Delegates strongly disapproves Recommendaiton No. 20 of the Governor's Commission, and that its opposition be transmitted to the proper authorities.

The Speaker: This will be referred to the Reference Committee on Legislation and Public Relations.

X—51. BROADENING OF THE MICHIGAN FOUNDATION FOR MEDICAL AND HEALTH EDUCATION, INC.

W. L. Brosius, M.D. [Wayne]:

Whereas, the Michigan State Medical Society sponsors the Michigan Foundation for Medical and Health Education, Inc., and

Whereas, new problems arise from time to time that could be satisfactorily referred to such a Foundation, and

Whereas, the Michigan Foundation for Medical and Health Education is doing excellent work in its designated fields; therefore, be it

RESOLVED: That the function of the Medical and Health Education Foundation be broadened to include charity and research; and be it further

RESOLVED: That the membership of the Foundation be broadened to include the delegates to the Michigan State Medical Society; and be it further

RESOLVED: That voluntary contributions from the membership of the Michigan State Medical Society be encouraged by inserting a space for that purpose on the annual dues statement; and be it further

RESOLVED: That the annual meeting be held during the annual meeting of the House of Delegates.

The Speaker: This will be referred to the Reference Committee on Miscellaneous Business.

XII. REPORTS OF COMMITTEES OF THE HOUSE OF DELEGATES

XII—A. ANNUAL AND SUPPLEMENTAL REPORTS OF THE COMMITTEE TO STUDY ASSOCIATION BETWEEN MSMS AND MICHIGAN MEDICAL SERVICE

C. L. Weston, M. D. [Owosso]: The Annual and Supplemental Reports of this Committee are in the Handbook. We have one addition we would like to give the appropriate reference committee to consider. I would like to add this to the Supplemental Report of the Committee. We have offered seven recommendations and we should like to add Recommendation No. 8 as follows:

"That the Michigan Medical Service Board exercise closer supervision over the administrative staff, especially in the areas of publicity and public relations."

The Speaker: These two reports and Recommendation No. 8 of the Committee are referred to the Reference Committee on Medical Service and Prepayment Insurance.

XII—B. REPORTS OF THE STANDING COMMITTEE ON CONSTITUTION AND BYLAWS

These reports are printed in the Handbook and are referred to the Reference Committee on Constitution and Bylaws.

XII—C. REPORT OF THE COMMITTEE TO STUDY THE PROBLEM OF THE INDIGENT OR ILL PHYSICIAN

This report is printed in the Handbook and is referred to the Reference Committee on Resolutions.

XII—D. REPORT OF THE COMMITTEE TO STUDY RELATIONSHIP BETWEEN DOCTORS OF MEDICINE AND OSTEOPATHS

This report is printed in the Handbook and is referred to the Reference Committee on Miscellaneous Business.

XII—E. REPORT OF THE COMMITTEE ON RELATIVE VALUE

This report is printed in the Handbook and is referred to the Reference Committee on Reports of Special Committees.

XIII. REPORTS OF STANDING COMMITTEES

These are all in the Handbook and will be referred to the Reference Committee on Reports of Standing Committees.

RESOLUTIONS (Continued)

X—52. MMS CONTRACTS FOR PERSONS OVER AGE 65

J. W. Rice, M.D. [Jackson]:

Whereas, the present contracts of Michigan Medical Service available to senior citizens over the age of 65 are satisfactory as to benefits, and have adequately served to make government-sponsored medical care for persons over 65 unnecessary, and

Whereas, the principle of community rating as opposed to experience rating is a traditional philosophy of Michigan Medical Service and is necessary to enable senior citizens to be able to afford the cost of the contracts made available for them; therefore be it

RESOLVED: That this 1962 House of Delegates reaffirms that medical care for senior citizens over the age of 65 be continued and supported by Michigan Medical Service through the principle of community rating ONLY.

The Speaker: That will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

X—53. EMERGENCY CARE IN HOSPITALS

H. A. Howes, M.D. [Wayne]:

Whereas, a special committee of the WCMS on hospital emergency service reported in April 1961 an increasing number of emergency visits, and

Whereas, the Committee of The Council of the Michigan State Medical Society to Study the Problem of Emergency Care in Hospitals in 1962 received a survey report from 168 hospitals in Michigan representing 54.5 per cent of beds, and

Whereas, 111 of these hospitals which had organized emergency room service in 1958 and 1961 reported treating 456,913 patients in 1958 and 585,289 in 1961, and 122 hospitals reported a total of 610,126 patients seen in 1961; therefore, be it

RESOLVED: That a special committee of the House of Delegates be appointed by the Speaker to study the future development of emergency care in hospitals in conjunction with the Michigan Hospital Association and the Michigan Hospital Service and Michigan Medical Service and with other carriers wishing to participate.

The Speaker: That will be referred to the Reference Committee on Miscellaneous Business.

X—54. CORRECTION OF ERROR IN MSMS BYLAWS

L. D. Bailey, M.D. [Wayne]:

Whereas, in the 1961 printing of the Bylaws an error was made in describing the number of Councilor Districts; therefore, be it

RESOLVED: That Chapter 10, Section 9 be worded to change the number of Districts from eighteen to fifteen, and that the reference to Wayne County in parentheses be deleted.

The Speaker: This will be sent to the Reference Committee on Constitution and Bylaws.

XI—D. LETTER OF APPRECIATION FROM IMMEDIATE PAST-PRESIDENT

The Speaker: I have a letter here from one of our Past Presidents that I would like to read to you. I think it is rather appropriate.

August 14, 1962

James J. Lightbody, M.D.
Speaker, House of Delegates
Michigan State Medical Society

Dear Jim—Mr. Speaker:

Since last September I have sought for the proper words to express my deep appreciation of the action of the Delegates concerning the resolution adopted by them in my behalf. The illuminated scroll, beautifully done, hangs in my consultation room. I confess that the words, also beautifully phrased, rather astound me and I sometimes wonder who was this guy about whom they speak. I would be less than human if I were not proud and deeply touched.

My time of service was a most rewarding experience, and I am only glad that I had the energy and time available to serve in my own small way the Michigan State Society and the physicians of Michigan. I needed no other reward, but I trust you will convey to the House my sincere appreciation for their action. It made me very happy.

Sincerely,
Kenneth H. Johnson, M.D.

MONDAY EVENING SESSION

September 24, 1962

The third meeting of the House of Delegates reconvened at 8:10 p.m., H. F. Falls, M.D., Vice Speaker of the House, presiding.

RESOLUTIONS (Continued)

X—55. OPPOSITION TO ENLARGEMENT OF GOVERNMENTAL ACTIVITIES IN THE PRACTICE OF MEDICINE

C. J. France, M.D. [Wayne]:

Whereas, there is a growing tendency on the part of the National Government to invade the practice of medicine through the enlargement of the jurisdiction of such national agencies as the National Institutes of Health, the Veterans Administration, the Food and Drug Administration, etc., and

Whereas, the government can best serve the people by carrying out the present responsibilities which these agencies have without enlarging their scope of activities; therefore, be it

RESOLVED: That the Michigan State Medical Society go on record as opposing the enlargement and extension of Federal Governmental responsibilities in the health field at this time.

The Vice Speaker: This will be referred to the Reference Committee on Legislation and Public Relations.

X—56. NATIONAL SURVEY OF KERR-MILLS OPERATION

H. A. Howes, M.D. [Wayne]:

Whereas, the successful operation of the Kerr-Mills law is of vital importance to the health care of many elderly Americans; therefore, be it

RESOLVED: That the Michigan State Medical Society request the American Medical Association to conduct or cause to be conducted a nation-wide survey of the operation of Kerr-Mills with the objective of making any changes deemed necessary to improve its operation.

The Vice Speaker: This will be referred to the Reference Committee on Medical Service and Prepayment Insurance.

X—57. PROBLEMS OF THE INDIGENT PHYSICIAN

R. G. Swanson, M.D. [Wayne]:

Whereas, a committee of the State Medical Society was appointed to study this problem of the indigent physician, and

Whereas, its questionnaire to the component county medical societies was confusing, and

Whereas, this placed an unfair clerical and financial burden on the county medical societies; therefore, be it

RESOLVED: That this committee be instructed to utilize State Society funds and personnel and keep in mind the delicate nature of the petinent information.

The Vice Speaker: This will be referred to the Reference Committee on Resolutions.

X—58. CONDUCT OF OPINION AND INFORMATION SURVEYS BY THE MICHIGAN STATE MEDICAL SOCIETY

R. E. Wunsch, M.D. [Wayne]:

Whereas, the 1961 House of Delegates requested a survey of opinion regarding the Relative Value Study Report, and

Whereas, the State Society passed this responsibility on to the county medical societies which constituted a financial burden to them, and

Whereas, this also fails to give comparable uniform results on a State-wide basis; therefore, be it

RESOLVED: That similar future requests from the House of Delegates be fulfilled directly by the Michigan State Medical Society with their own funds and personnel.

The Vice Speaker: This will be referred to the Reference Committee on Miscellaneous Business.

X—59. UNEMPLOYMENT AND WORKMEN'S COMPENSATION ACTS

Charles Darling, M.D. [Wayne]:

Whereas, the operation of the Unemployment and Workmen's Compensation Acts have a marked effect on the health of the people, and

Whereas, the Michigan State Medical Society has a Committee on Occupational Health consisting of doctors of medicine who are especially qualified in those factors of health affected by the operation of the Acts noted; therefore, be it

RESOLVED: That The Council of the Michigan State Medical Society be requested to assign to the Occupational Health Committee the task of analyzing the operation of the Unemployment and Workmen's Compensation Acts; and be it further

RESOLVED: That the Committee recommend such changes as will improve the Acts in relation to health and sound philosophies of medical care.

The Vice Speaker: This will be referred to the Reference Committee on Legislation and Public Relations.

X—60. CONSOLIDATION OF STATE HEALTH AGENCIES

G. T. McKean, M.D. [Wayne]:

Whereas, a multiplicity of State agencies are directly involved in supplying health care and advice to the State, and

Whereas, this multiplicity has resulted in confusion, duplication, varied methods of care and payment, and contradictions of policy, and

Whereas, the Constitutional Convention investigation committees decried this situation and recommended consolidating of all agencies directly concerned with health; therefore, be it

RESOLVED: That The Council of the Michigan State Medical Society establish a study committtee to investigate the merit of this proposal.

The Vice Speaker: This will be referred to the Reference Committee on Hygiene and Public Health.

X—61. DRIVER-OPERATOR LICENSE

W. C. Beets, M.D. [Kent]:

Whereas, there is an increasing and alarming auto accident rate in this State and other states, and

Whereas, a high percentage of auto accidents are attributable to human error and physical or emotional incapacity of the operator, and

Whereas, the physician is presently legally required to report communicable diseases which affect the public safety, and

Whereas, the physician is usually aware of newly acquired physical incapacities which would render a person an unsafe operator on our major highways, and

Whereas, our present laws do not provide for adequate interim driver examinations, and

Whereas, there is no provision for the reporting of such newly acquired physical and emotional conditions which might affect a person's ability to safely operate a motor vehicle on major highways; therefore, be it

RESOLVED: That MSMS recommend the establishment of a study committee of MSMS, the State Bar of Michigan and Governor's representatives (Secretary of State) to develop legislative recommendations to improve the methods of detection, evaluation and reporting of such newly acquired physical and emotional condi-

tions which might seriously affect a person's ability to safely operate a motor vehicle.

THE VICE SPEAKER: This will be referred to the Reference Committee on Hygiene and Public Health.

X—62. MEDICAL TRAINING FACILITIES IN GRAND RAPIDS

W. C. BEETS, M.D. [Kent]:

Whereas, there is a need for establishing additional medical training facilities in the State of Michigan, and

Whereas, the success of medical training is dependent upon a large population, superior hospital facilities and skilled professional personnel, and

Whereas, Grand Rapids, as the second largest city in the State, with an expanding population in Western Michigan, would provide adequate clinical material for the training of medical students, and

Whereas, Grand Rapids already has three general hospitals with 1,500 beds and approved training programs in the specialties, with six additional recognized supporting hospitals providing specialized services in chronic disease, mental disease, rehabilitation, etc., and with four colleges for higher education in the area; therefore, be it

RESOLVED: That the Michigan State Medical Society recommend immediate plans be made to utilize the existing facilities in Grand Rapids for the training of medical students in their clinical years.

THE VICE SPEAKER: This will be referred to the Reference Committee on Resolutions.

X—63. BUILDING NEW BEDS IN THE PROPOSED MEDICAL CENTER

A. W. BLAIN, M.D. [Wayne]:

Whereas, a consultant by the name of Dr. Anthony O'Rourke was hired in the recent past to come to Detroit and proposed the building of a large medical center, which entails the moving of the Wayne State University Medical School to the vicinity of Harper and Grace Hospitals, and

Whereas, for over sixty years the Wayne State University Medical School, formerly the Detroit College of Medicine, has been handicapped by the lack of a university hospital which would admit charity and private patients and be directly under the control of the Medical School; therefore, be it

RESOLVED: That The Council of the Michigan State Medical Society appoint a conmittee to study the proposition that if any new hospital beds are to be financed in the envisioned new medical center, they first be allocated to a Wayne State University hospital; and be it further

RESOLVED: That some of the members of this committee include the alumni and clinical faculty of the Wayne State University College of Medicine.

THE VICE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

X—64. COMPOSITION OF AMA COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

J. A. FERGUSON, M.D. [Kent]:

Whereas, the House of Delegates of the AMA referred to the AMA Board of Trustees a proposal that at least six members of the Council on Medical Education and Hospitals shall be engaged primarily in the private practice of medicine in hospitals without a medical school affiliation and that not more than four members may be salaried personnel of a medical school or university; therefore, be it

RESOLVED: That the MSMS House of Delegates urge the AMA Board of Trustees to implement this proposal; and be it further

RESOLVED: That a copy of this resolution be forwarded to the Board of Trustees of the AMA.

THE VICE SPEAKER: This will be referred to the Reference Committee on Resolutions.

X—65. HONORARIUM FOR OFFICERS

F. C. RYAN, M.D. [Kalamazoo]:

Whereas, the American Medical Association has approved payment of an honorarium to elected officers, and

Whereas, the costs to an individual practicing physician serving as an elected officer of the Michigan State Medical Society has become increasingly great, and

Whereas, this has resulted in a tendency to choose officers who are salaried M.D.s; therefore, be it

RESOLVED: That the House of Delegates instruct The Council to take steps toward the establishment of an honorarium to be paid to elected officers of the Michigan State Medical Society.

THE VICE SPEAKER: This will be sent to the Reference Committee on Miscellaneous Business.

XIV. REPORTS OF REFERENCE COMMITTEES

XIV—1. ON CONSTITUTION AND BYLAWS

XIV—1(a) REVISED MSMS CONSTITUTION

F. P. RHOADES, M.D.:

Your Reference Committee approves the proposed MSMS Constitution containing amendments as recommended by the 1961 MSMS House of Delegates, and recommends its adoption.

You have all received copies of this, and in effect you realize that it is just a rewording of the Constitution for simplification and clarity, and that there are no fundamental changes.

I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—1(b) ANNUAL AND SUPPLEMENTAL REPORTS OF THE STANDING COMMITTEE ON CONSTITUTION AND BYLAWS

We agreed to retain the Constitution and rejected Articles of Incorporation as a substitute. This would call for periodic revisions.

I move approval of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—1(c) SUPPLEMENTAL ANNUAL REPORT OF THE COUNCIL NO. 2 AND RESOLUTIONS NOS. 22 AND 24

Resolution No. 22, "Change in the Duties of the MSMS Secretary and of the Executive Director," along with Resolution No. 24, having the same title, were considered together, since they both were intended to implement Supplemental Report No. 2 of The Council.

Your Reference Committee therefore recommends adoption of Resolution No. 22 and no action on Resolution No. 24.

I move the approval of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—1(d) RESOLUTION NO. 3

Your Reference Committee approves the intent of this Resolution. That part of the Resolution requiring a constitutional amendment must lie over for one year. This and the remainder of the Resolution were approved in principle, and we recommend that they be committed to the House of Delegates' Standing Committee on Constitution and Bylaws.

I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—1(e) RESOLUTION NO. 9

The Reference Committee agrees with the intent of Resolution No. 9, having to do with expediting the procedure in appeal cases, and your Reference Committee submits the following substitute "RESOLVED" portion:

RESOLVED: Revise Chapter 6, Section 14, Sentence 9 by inserting the following: "The Committee on Ethics shall, within sixty days of receiving the full records in the case, make a report in writing to The Council," and so on; and revise sentence 10 to read: "The Council shall, within sixty days after the filing of such report," and so on.

I move adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—1 (f and g) RESOLUTIONS NOS. 13 AND 15

The Reference Committee agrees that Chapters 6 and 7 of the Bylaws, entitled "Conduct and Discipline of Members" and "Grievances of Nonmembers—Mediation Committee" of the Bylaws could profitably be simplified, and hence recommends that Resolutions Nos. 13 and 15 be referred to the Standing Committee on Constitution and Bylaws of the House for implementation of this request.

I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—1(h) RESOLUTION NO. 23

The Reference Committee approved the resolution, since it will correct and equalize the number of MSMS Councilors elected each year.

I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—1(i) RESOLUTION NO. 54

Your Reference Committee recommends the adoption of this Resolution, and I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

F. P. Rhoades, M.D.: The Reference Committee now moves the adoption of this entire report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—2 ON HYGIENE AND PUBLIC HEALTH

XIV—2(a) RESOLUTION NO. 7

Resolution No. 7, regarding "Health and Physical Fitness of School Children," was approved unanimously as written.

I move the acceptance of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—2(b) RESOLUTION NO. 10

After lengthy discussion by the guests present, for and against this Resolution, the Reference Committee was declared in executive session, and the resolution was passed as read.

I move the adoption of Resolution No. 10.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—2(c) RESOLUTION NO. 45

This Resolution was reviewed and approved in principle, with the "Resolved" portion changed to read:

RESOLVED: That the Michigan State Medical Society strongly urge the appropriate professional, collegiate, primary and secondary school officials in this State to study and develop a change in the type of helmet used by football players, to provide greater safety.

This was passed unanimously. I move the adoption of the resolution as amended.

[*The motion was duly seconded.*]

G. A. Drake, M.D.: I will change my "Resolved" portion as originally written and offer it as an amendment to the "Resolved" portion presented by the Reference Committee:

"RESOLVED: That the Michigan State Medical Society urge the appropriate professional, collegiate, primary and secondary school officials in this State to give strong consideration to the removal of the face mask and the application of appropriate padding to the crown and occipital margin of the helmet."

I so move.

[*The motion was duly seconded.*]

The Vice Speaker: I shall call for the question on the amended "Resolved." All those in favor, say "aye"; opposed, same sign. It is carried.

Now, we shall vote on the resolution as submitted by Dr. Segar and as amended by his Reference Committee. All those in favor, say "aye"; opposed, same sign. It is carried.

X—66. REPORTING OF VENEREAL DISEASE

L. F. Segar, M.D. (Chairman of Reference Committee on Hygiene and Public Health):

Whereas, evidence from the Public Health Service demonstrated an appreciable increase in the incidence of venereal disease recently, and

Whereas, some physicians have failed to report these diseases as required by law, and

Whereas, the Public Health Commissioner of Michigan has decreed all laboratories must report positive serologies directly to local health departments as a means of finding all cases of venereal disease, this involving a violation of the patient-physician relationship; therefore, be it

RESOLVED: That the Michigan State Medical Society explore ways and means of reminding the physicians of their responsibility in reporting venereal disease; and be it further

RESOLVED: That this matter be brought to the attention of the entire membership of the Michigan State Medical Society through the President's Letter.

The Vice Speaker: I shall send this resolution to the Reference Committee on Resolutions.

SUPPLEMENTAL REPORT OF REFERENCE COMMITTEE ON HYGIENE AND PUBLIC HEALTH

XIV—2(d) RESOLUTION NO. 60

L. F. Segar, M.D.: Resolution No. 60, concerning the consolidation of State health agencies, was reviewed and unanimously approved as written.

I move the adoption of this resolution.

[*The motion was duly seconded.*]

The Speaker: The motion is to approve Resolution No. 60 as printed.

[*The motion was put to a vote and was carried unanimously.*]

XIV—2(e) RESOLUTION NO. 61

This resolution has been carefully reviewed and unanimously passed by the Reference Committee as read.

Mr. Speaker, I move adoption of the resolution. It has to do with a study, with no definite commitments but a study of this problem.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

L. F. Segar, M.D.: Mr. Speaker, I move the adoption of this supplemental report as a whole.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—5. ON MISCELLANEOUS BUSINESS

XIV—5(a) ANNUAL REPORT OF COMMITTEE TO STUDY RELATIONSHIP BETWEEN DOCTORS OF MEDICINE AND OSTEOPATHS

C. W. Colwell, M.D.: Your Reference Committee recommends that the report of the Committee to Study Relationship Between Doctors of Medicine and Osteopaths be received for information, and that a deletion be made in their first recommendation on page 8 so that it would now read:

"1. That the House of Delegates affirm the time-honored principle that all questions of ethics, including the ethical relationship between individual M.D.s and D.O.s, originate with the State Society, which shall assume jurisdiction in accordance with the provisions in this regard, as set forth in the Constitution and Bylaws."

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded.*]

J. B. Blodgett, M.D. [Wayne]: I move to recommit this portion of the report to the Reference Committee.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—5(b) RESOLUTION NO. 33

C. W. Colwell, M.D.: The next resolution considered by the Reference Committee was Resolution No. 33, the context of which is on Joint Accreditation Committee Policy.

Your Reference Committee disapproves this resolution, with the recommendation that it be resubmitted with more information at a later date.

I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—5(d) RESOLUTION NO. 40

C. W. Colwell, M.D.: Your Reference Committee recommends the adoption of this resolution, recommending that the word "permanent", where it appears in three different places, be changed to "regular". I will read it as it would be reworded:

Whereas, the governing boards of the hospitals of the State of Michigan do not uniformly have one or more physicians as regular voting members to represent and interpret the position of the medical and surgical practices and the affairs of the hospital; therefore, be it

RESOLVED: That all hospital governing boards be requested to have at least one physician as a regular voting member of the board, and that at least one physician be a regular voting member of the executive committee of the board, and that the physician or physicians serving on the board be members of the active medical staff of the hospital and be nominated by the medical staff of the hospital.

Your Reference Committee moves the adoption of this resolution as just amended.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—5(e) RESOLUTION NO. 47

C. W. Colwell, M.D.: Your Reference Committee approves this resolution.

I move that this portion of the Reference Committee's report be adopted.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—5(f) RESOLUTION NO. 51

C. W. Colwell, M.D.: Your Reference Committee spent a great deal of time on this and a lot of people testified in its behalf. Your Reference Committee accepted this resolution with the following amendment, which reads as follows:

Whereas, the Michigan State Medical Society originally helped sponsor the Michigan Foundation for Medical and Health Education, Inc., and

Whereas, new problems arise from time to time that could satisfactorily be referred to such a Foundation, and

Whereas, the Michigan Foundation for Medical and Health Education is doing excellent work in its designated fields; therefore, be it

RESOLVED: That the Michigan Foundation for Medical and Health Education, Inc., be invited to broaden their functions to include charity and research; and be it further

RESOLVED: That voluntary contributions from the membership of the Michigan State Medical Society be encouraged.

We move the adoption of this portion of the report as amended.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—5(g) RESOLUTION NO. 53

C. W. Colwell, M.D.: Your Reference Committee recommends the adoption of this resolution, with the recommendation that the Resolved portion be amended to read as follows:

RESOLVED: That a special committee of the House of Delegates be appointed to study the present practice and future developments of medical care in hospital emergency rooms with particular reference to the questions: (1) The propriety of hospitals engaging in the practice of medicine; (2) the conditions under which a fee for service by the responsible physician may be submitted.

Your Reference Committee recommends the adoption of this portion of the report as amended.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

SUPPLEMENTAL REPORT OF REFERENCE COMMITTEE ON MISCELLANEOUS BUSINESS

XIV—5(a). REPORT OF COMMITTEE TO STUDY RELATIONSHIP BETWEEN DOCTORS OF MEDICINE AND OSTEOPATHS

C. W. Colwell, M.D.: The first subject considered was the Annual Report of the Committee to Study the Relationship Between Doctors of Medicine and Osteopaths.

This matter was sent back to our Reference Committee for reconsideration by the House of Delegates.

Your Reference Committee recommends that this report be accepted, with the first recommendation on page 8 of the report to be amended to read as follows:

> "That the House of Delegates affirm the practice in which the State Society establishes the principles of ethical relationship between doctors of medicine and osteopaths, recognizing that complaints in this regard originate at the county level, and further that the individual physician should be responsible to his local society."

I move that this portion of the report be adopted.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

C. W. Colwell, M.D.: Your Reference Committee further recommends that the following statement be added to the fifth recommendation on page 9 of the report, which is as follows:

"That the Committee 'ad hoc' formulate as soon as possible proper principles having to do with the ethical relationship between doctors of medicine and doctors of osteopathy."

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—5(c). RESOLUTION NO. 38

C. W. Colwell, M.D.: Your Reference Committee is unanimously cognizant of the dedicated service rendered to the Michigan State Medical Society by Dr. Drolett over the past fifteen years, and it is not our intent to detract from this commendation in any way. We do feel, however, that the awarding of an illuminated scroll attesting to this service might well be establishing a precedent to be followed in the future. We also discussed the fact that this particular procedure could possibly usurp the prerogative of the Committee on Certificates of Commendation.

Your Reference Committee therefore recommends the adoption of the resolution with the deletion of the last Resolved.

Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—5(h). RESOLUTION NO. 58

C. W. Colwell, M.D.: Your Reference Committee recommends the adoption of this resolution with the following amendments:

"Whereas, the 1961 House of Delegates requested a survey of opinion regarding the Relative Value Study Report, and the State Society passed this responsibility on to the county medical societies, and

"Whereas, this fails to give comparable uniform results on a State-wide basis; therefore, be it

"RESOLVED: That similar future requests for surveys from the House of Delegates shall be conducted directly by the Michigan State Medical Society."

Mr. Speaker, I move that this portion of the report be adopted.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—5(i). RESOLUTION NO. 65

Your Committee recommends that the resolved portion of this resolution be amended to read as follows:

"That the House of Delegates instruct the Speaker of the House to appoint a committee to study this problem and make recommendations relative to an Honorarium for Officers and make a report to this House of Delegates at the next regular session."

Mr. Speaker, I move that this portion of the report, as amended, be adopted.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—6. ON REPORTS OF THE COUNCIL

XIV—6(a). ANNUAL AND SUPPLEMENTAL REPORTS OF THE COUNCIL

J. M. Wellman, M.D.: Your Reference Committee considered the Annual Report of The Council as published in the Handbook and the Supplemental Report of The Council dated September 23, 1962. Your Reference Committee is impressed by the tremendous amount of work that has been accomplished by members of The Council, the members of its various committees, and expresses our sincere thanks to them. In addition, we commend Mr. Lester P. Dodd, Legal Counsel; Dr. Wilfrid Haughey, Editor of The Journal, and members of the administrative staff of MSMS for their splendid efforts on behalf of our Medical Society.

Your Reference Committee reviewed the numerous items in these reports, and we will take up specifically only those items which require action by this House of Delegates.

Report of the Committee on Professional Insurance Plans

J. M. Wellman, M.D.: This report was discussed with the Committee by its Chairman, Dr. Falls. The Committee approved a motion that professional insurance plans and coverage be based upon the recognition of professional courtesy. Your Reference Committee benefited by presentations in this discussion by Report of the Committee on Professional Insurance Plans.

Dr. Falls, Chairman of this Committee, discussed this report in detail, and in addition excellent information was furnished by Mr. Ben Stratton, Insurance Consultant to MSMS, and Mr. William Flaherty of Michigan Medical Service.

By motion, your reference Committee approved that professional courtesy be one of the basic tenets in consideration of professional insurance plans. Your Reference Committee recommends approval of the changes mentioned in this report to improve the insurance coverage to MSMS members.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

J. M. Wellman, M.D.: Your Reference Committee urges continuation of the very excellent liaison with the Michigan Chapter of the Health Insurance Council. In consideration of major medical insurance coverage, your Reference Committee recommends that the Committee on Professional Insurance Plans continue to develop the details in this matter and offer such coverage to MSMS members after approval is given by the MSMS Council.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

J. M. Wellman, M.D.: Your Reference Committee wishes to pay special tribute to Dr. Falls and the members of his Committee, and also to express our sincere appreciation for the help and contributions of Mr. Stratton and Mr. Flaherty.

Committee on Recruitment of Superior Medical Students and the Need for Financial Aid: Your Reference Committee considered the report of this Committee in detail, including the recommendations that it made for continued support in this endeavor.

Your Reference Committee recommends that the report of this Committee of The Council be approved with the stipulation for a one-time $10 assessment per member of MSMS, with the understanding that funds contributed by this assessment shall be returned by the AMA Education and Research Foundation to the medical schools in Michigan.

Mr. Speaker, I so move.

[*The motion was duly seconded.*]

The Speaker: Those in favor, say "aye"; those opposed, "no." It is carried.

Report of the Committee to Study Problems of Emergency Care in Hospitals

J. M. Wellman, M.D.: Your Reference Committee expresses its appreciation for the work which this Committee has done and, in view of its request, recommends that the results of this survey be placed in the hands of a

special committee of the House of Delegates, empowering it and instructing it to study the future developments of this problem in conjunction with the Michigan Hospital Association, Michigan Medical Service, Michigan Hospital Service, and other carriers wishing to participate, and further recommends that this present Committee to Study the Problem of Emergency Care in Hospitals be discharged.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

Report of the Committee on Hospital Relations

J. M. Wellman, M.D.: Your Reference Committee notes that this Committee of The Council has developed definitions of its purposes as outlined in its report, and recommends that this Committee continue its activities.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

J. M. Wellman, M.D.: Recommendations of The Council will be found on page 17 of the Supplemental Report.

1. Your Reference Committee recommends that The Council be authorized to arrange Councilor conferences prior to the 1963 Annual Session.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

2. Your Reference Committee recommends that The Council be authorized to prepare and distribute to each member of MSMS an Annual Report of MSMS, to be mailed with the digest of the Proceedings of the House of Delegates.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

3. Your Reference Committee recommends approval of this recommendation of The Council relative to "State Society Night Programs."

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

4. Your Reference Committee recommends approval of this recommendation from The Council relative to MSMS representatives being sent to Washington, D. C., in 1963 on "Michigan Day."

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

5. Your Reference Committee recommends approval of this House of Delegates again encouraging more component societies to send delegations of members to Washington, D. C., to discuss legislative matters with their elected congressmen.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

6. Your Reference Committee recommends approval of this recommendation from The Council relative to the public problem of physical fitness.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

7. Your Reference Committee recommends that the Michigan medical profession give increased support to the medical self-help program of the AMA.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

8. Your Reference Committee recommends approval of this recommendation from The Council relative to county society constitution and bylaws, with the addition that each county society be requested to forward a copy of its constitution and bylaws to MSMS for review.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

9. Your Reference Committee recommends approval of this suggestion that Michigan medical schools be encouraged to increase their teaching and research efforts regarding alcoholism.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

Report of Finance Committee

The Financial Report as published in the Supplemental Report and the additional report given by Dr. Warren W. Babcock, Chairman of the Finance Committee of The Council were reviewed with Dr. Babcock. We commend him and the members of his committee.

Mr. Speaker, I move the adoption of the report of this Reference Committee in its entirety.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—7. ON REPORTS OF OFFICERS

XIV—7(a). THE SPEAKER'S REMARKS

R. E. Wunsch, M.D.: The Reference Committee accepts the Speaker's remarks with commendation.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—7(b). PRESIDENT'S REMARKS

The Reference Committee accepts the President's Address and commends the President for his efficient conduct in office this past year.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—7(c). PRESIDENT-ELECT'S REMARKS

The Reference Committee accepts the address with best wishes for the coming year.

The Reference Committee wishes to re-emphasize the President-elect's commendation of Dr. Falls and the Medical Socio-Economic Committee for the great amount of work entailed in alerting the membership of the Michigan State Medical Society to the dangers to medical practice inherent in the report of the Governor's Commission on Prepaid Hospital and Medical Care Plans.

The Reference Committee wishes to also especially commend Dr. Falls for the vast amount of work he has done as consultant to the Governor's Commission.

The Reference Committee especially notes his remarks regarding the Michigan Foundation for Medical and Health Education, Inc.

The Reference Committee also notes that a resolution has been introduced into the House of Delegates implementing the President-elect's recommendations.

The Committee recommends to the Reference Committee support of this resolution.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—7(d). REPORT OF DELEGATES TO THE AMA

The Reference Committee accepts the report and expresses its opinion that the Michigan State Medical Society has been well represented in the House of Delegates of the AMA.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—7(f). REPORT OF THE PRESIDENT OF THE MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

The Reference Committee accepts the report of Miss Rutan, President, with thanks and appreciation.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—7(e). REPORT OF PRESIDENT OF WOMAN'S AUXILIARY TO THE MICHIGAN STATE MEDICAL SOCIETY

The Reference Committee accepts Mrs. Owen's report and wishes to express appreciation for the tremendous amount of personal sacrifice involved in the fulfillment of her duties. We further acknowledge the very great help she and the Auxiliary have given the Michigan State Medical Society.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

R. E. Wunsch, M.D.: Mr. Speaker, I move the adoption of this report as a whole.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—9. ON REPORTS OF STANDING COMMITTEES

J. B. Blodgett, M.D.: The Reference Committee on Reports of Standing Committees has reviewed the reports of the standing committees and is impressed with the fine work of these committees and the dedicated service of the committee members to the Michigan State Medical Society.

All committees are highly commended for the quality of their work and the accomplishments in their reports. These reports are published in the Handbook and should be read by every member of the House. The Reference Committee has studied these reports individually and wishes to make certain comments and recommendations with respect to the following committee reports:

XIV—9(a). ANNUAL REPORT OF THE COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

We note the excellence of attendance at the intra- and extramural program, and that two new centers of education have been established at Cass City and Petoskey at the request of the local physicians.

XIV—9(b). COMMITTEE ON MATERNAL HEALTH

The Committee on Maternal Health reported that two new regional committees were being established, one in Roger City and one in Coldwater.

XIV—9(c). COMMITTEE ON VENEREAL DISEASE

The Reference Committee viewed with concern the apparent rising incidence in cases of primary and secondary syphilis. In 1958 and 1959 seventy-nine cases were reported; in 1959 to 1960, 146 cases; and in 1960 to 1961, 280 cases. These were primarily in the age group of 10 to 19 years.

This Reference Committee feels that it is important that it be established whether physical examination and treatment by a registered physician, acting upon the authority of the county or city department of health, upon the person of a minor who voluntarily appears, does or does not constitute an assault or an assault and battery upon said person. This Reference Committee approved the opposition of The Council of the MSMS to the reporting by laboratories of positive serological reactions.

XIV—9(d). COMMITTEE ON CANCER CONTROL

In reviewing the Annual Report of the Committee on Cancer Control, this Reference Committee notes and approves the standardization of the nomenclature and reporting form, and expresses its confidence in and appreciation to the Director of the Cancer Registry, Dr. Isidore Selzer.

XIV—9(e). COMMITTEE ON OCCUPATIONAL MEDICINE

The Reference Committee studied the Annual Report of the Committee on Occupational Medicine and is impressed with the importance and scope of this Committee in this industrial State, and urges full study of this important subject by the Committee on Occupational Medicine.

Mr. Speaker, I move the approval of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—9(f). COMMITTEE ON MENTAL HEALTH

J. B. Blodgett, M.D.: In studying the Annual Report of the Committee on Mental Health, it is noted that the Committee on Mental Health recommends that the Michigan State Medical Society should delegate two official representatives to attend the Mental Health Department public meetings. The Reference Committee recommends that this be done and that provision be made for expenses incurred. These two delegates should be chosen by The Council, preferably from the Committee on Mental Health.

Our Reference Committee wishes to emphasize the recommendation of the Committee on Mental Health that the first AMA Congress on Psychiatry, to be held on October 4-5-6 in Chicago, receive the full support of every MSMS member.

We move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—9(g). COMMITTEE ON GERIATRICS

J. B. Blodgett, M.D.: Attention is called to the portion of the report of the Committee on Geriatrics in which they indicate that several studies made in key counties throughout the State have shown that the Kerr-Mills law has been functioning well through the State except in Wayne County, where the local Department of Social Welfare, which administers the law, pays only 75 per cent of hospital costs. Efforts on a State and county level have not been effective in changing this dictum of the Welfare Director.

XIV—9(h). COMMITTEE ON HIGHWAY ACCIDENT PREVENTION

In the Annual Report of the Committee on Highway Accident Prevention, your Reference Committee emphasizes the importance of the county medical advisory boards being of assistance to the Department of State in cases where a driver's license has been suspended and a physical condition detrimental to driving may exist. The various county medical societies are urged to provide such medical advisory boards to assist the public authorities.

XIV—9(i). COMMITTEE ON PUBLIC RELATIONS

The Committee on Public Relations is highly commended for carrying out its vast program in behalf of American and Michigan medicine and the people of this State.

XIV—9(j). APPROVAL OF OTHER MSMS COMMITTEE REPORTS

The remainder of the committee reports are accepted as printed in the Handbook.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

J. B. Blodgett, M.D.: Mr. Speaker, I move the adoption of the report as a whole.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—10. REFERENCE COMMITTEE ON RESOLUTIONS

XIV—10(a). REPORT OF COMMITTEE TO STUDY PROBLEM OF INDIGENT OR ILL PHYSICIAN

The Reference Committee recommends that a permanent committee of The Council be appointed for continuing investigation of the indigent and/or ill physician. the committee to be composed of a chairman and five members, and to report annually to The Council or oftener if deemed necessary.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

Mr. Speaker, I move the adoption of the Reference Committee's reports as presented so far.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—10(b). RESOLUTION NO. 2

L. A. Drolett, M.D.: It was brought out in the Reference Committee that these polls are rather expensive, and after considerable discussion the Reference Committee agreed to submit a substitute resolution in lieu of present Resolution No. 2. The substitute resolution would read as follows:

"Whereas, the House of Delegates of the Michigan State Medical Society in 1961 authorized a poll of the members regarding Social Security, and

"Whereas, the questionnaire was subject to misinterpretation; therefore, be it

"RESOLVED: That the Michigan State Medical Society again poll its membership in regard to inclusion in OASI (Social Security) by the following question: 'Do you favor the inclusion of physicians under Social Security?'; and be it further

"RESOLVED: That an explanatory statement be enclosed, stating, 'If the majority of physicians favor inclusion it is mandatory for all'; and be it further

"RESOLVED: That the results of the poll be transmitted to the House of Delegates of the AMA for their action."

Mr. Speaker, I move the adoption of substitute Resolution No. 2.

[*The motion was duly seconded.*]

The Vice Speaker: The question is called for. Those in favor, please say "aye"; opposed, same sign. I will call for a hand vote. Those in favor, raise your right hand; those opposed, the same. The vote is in favor of the substitute resolution, and it is carried.

XIV—10(c). RESOLUTION NO. 6

The "Resolved" portion reads:

"RESOLVED: That The Council, the President and the Legal Affairs Committee be accorded the sincere appreciation of the House of Delegates of the Michigan State Medical Society for leadership and stimulation of the membership to help defeat radical legislation in the Congress of the United States inimical to the best interests of the health of the American people."

Mr. Speaker, the Reference Committee recommends that this resolution be approved as presented.

I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—10(d). RESOLUTION NO. 8

Your Reference Committee recommends approval of this resolution with an amendment to add the words "by The Council," meaning that the committee be appointed by The Council. The "Resolved" portion would read:

"RESOLVED: That the Michigan State Medical Society study possible means for evaluating the medical care of non-hospitalized patients either through an existing committee or by formation of a new special committee by The Council."

I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—10(e). RESOLUTION NO. 18

"RESOLVED: That the House of Delegates of the Michigan State Medical Society favor the inclusion of doctors of medicine in Old Age Survival Insurance and to instruct its delegates to the American Medical Association to implement this decision."

The Reference Committee disapproved this resolution on the basis of a recommendation that a new substitute Resolution No. 2 was being presented.

I move the action of the Reference Committee.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—10(f). RESOLUTION NO. 21

"RESOLVED: That the Michigan State Medical Society commend them for their increasing knowledge, training, and valuable assistance; and be it further

"RESOLVED: That the official greetings of the Michigan State Medical Society be extended to them; and be it further

"RESOLVED: That a copy of this resolution be sent to the American Association of Medical Assistants."

The Reference Committee recommends unanimous approval of this resolution, and I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—10(g). RESOLUTION NO. 31

"RESOLVED: That this House of Delegates again urges every Michigan physician, his wife and family to participate in the November 6 election and to urge everyone with whom they come in contact to do likewise; and be it further

"RESOLVED: That the Michigan medical profession pledge itself to assist, whenever and wherever possible, the ill, disabled and shut-in to obtain absentee ballots so that they will not be denied their right, privilege and responsibility to vote."

Mr. Speaker, I move the adoption of this resolution.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—10(h). RESOLUTION NO. 39

The "Resolved" part of Resolution No. 39 was amended to read:

"RESOLVED: That the House of Delegates of the Michigan State Medical Society recommend to all the

members of the MSMS that they join the Michigan Association of the Professions and actively participate and support its programs and that MSMS be urged to actively participate and support the principles of MAP."

I move that the resolution be adopted as amended.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—10(i). RESOLUTION NO. 41

"RESOLVED: That the officers of the component county medical societies be polled each year for advice concerning nominations to the various State Medical Society committees."

The Reference Committee recommends that this resolution be approved, and I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—10(j). RESOLUTION NO. 48

"RESOLVED: That the Michigan State Medical Society adopt the policy that the doctor be disassociated from Blue Cross in the dissemination of all information to the public; and be it further

"RESOLVED: That the Michigan State Medical Society investigate the possibility of using the name MICHIGAN DOCTORS SERVICE in public utterances instead of Blue Shield or Michigan Medical Service; and be it further

"RESOLVED: That Michigan Medical Service be urged to implement this policy."

After considerable discussion it was recommended that this resolution be disapproved at this time because it would create an unnecessary amount of publicity in the public press.

I so move.

[*The motion was duly seconded, was put to a vote, and was carried.*]

SUPPLEMENTAL REPORT OF REFERENCE COMMITTEE ON RESOLUTIONS

XIV—10(k). RESOLUTION NO. 57

The Reference Committee recommends that this resolution be disapproved, as the subject matter has been taken care of by a previous resolution. Further, the Reference Committee suggests that pertinent information regarding the indigent and/or ill physician be gathered by the component medical societies and forwarded to the five-man committee requested to be appointed by The Council; if State help is deemed necessary, it will be welcomed.

Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—10(l). RESOLUTION NO. 62

The Reference Committee recommends that this resolution be approved as written.

I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—10(m). RESOLUTION NO. 63

The Reference Committee recommends that this resolution be disapproved and that the matter be referred to the Wayne County Medical Society for further study.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—10(n). RESOLUTION NO. 64

The Reference Committee recommends that this resolution be approved as written.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—10(o). RESOLUTION NO. 66

The Reference Committee recommends that this resolution be approved as written.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

L. A. Drolett, M.D.: Mr. Speaker, I move the adoption of the entire report of the Reference Committee on Resolutions.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—11. ON SPECIAL MEMBERSHIPS

XIV—11(a). LIFE MEMBERSHIPS

C. L. Weston, M.D.: The Reference Committee on Special Memberships has reviewed all the resolutions presented for Life Memberships. The names have been accredited by their local medical society and by the Membership Department of the Michigan State Medical Society. They have been checked and approved by the Reference Committee. They are as follows:

Allegan County—William R. Vaughn, M.D.
Calhoun County—Robert H. Fraser, M.D.
Eaton County—Fred L. Arner, M.D.
Gratiot-Isabella-Clare—Melvin J. Budge, M.D.
Ingham County—Russell E. Palmer, M.D.
Jackson County—William E. McGarney, M.D.
Kent County—R. Earle Smith, M.D., and Sumner M. Wells, Jr., M.D.
Macomb County—George F. Moore, M.D., Allen B. Bower, M.D., William J. Kane, M.D., and Milton C. Smith, M.D.
Manistee County—Ellery A. Oakes, M.D.
Marquette-Alger County—Raymond A. Tearnan, M.D.
Menominee County—John W. Towey, M.D., and Karm C. Kerwell, M.D.
Muskegon County—Saul G. Cohan, M.D., Clifford B. Mendeville, M.D., and Constantine L. A. Oden, M.D.
Newaygo County—Lambert J. Geerlings, M.D.
Oakland County—Edmund D. Margrave, M.D.
Ottawa County—William Westrate, Sr., M.D., and Cornelius E. Boone, M.D.
Sanilac County—John Clyde Webster, M.D.
Shiawassee County—A. L. Arnold, M.D.
Wayne County—Lloyd K. Babcock, M.D., William L. Brosius, M.D., Arthur H. Cameron, M.D., James G. Carr, M.D., Norman E. Clarke, M.D., Louis D. Cotruro, M.D., Leon B. Cowen, M.D., Thomas H. Crews, M.D., Frank E. Curtis, M.D., Ira G. Downer, M.D., Aaron Dubnove, M.D., Hugh S. Foley, M.D., Laslo L. Galdonyi, M.D., Nathan H. Goldberg, M.D., A. S. Guimares, M.D., Robert J. Hall, M.D., Clyde K. Hasley, M.D., Eugene Laurisin, M.D., Nixon R. Lawhead, M.D., Charles T. Lewis, M.D., John W. MacKenzie, M.D., John J. McClintock, M.D., Angus L. McDonald, M.D., Robert J. McPherson, M.D., Vasil P. Moisides, M.D., Carlin P. Mott, M.D., William F. Nill, M.D., Arthur B. Norton, M.D., Robert L. Novy, M.D., Hyman L. Perlis, M.D., Orlando W. Pickard, M.D., Ralph H. Pino, M.D., Mary H. Rieger, M.D., Edward T. Roth, M.D., Arthur E. Schiller, M.D., Louis D. Stern, M.D., Hugh A. Sullivan, M.D., Charles L. Tomsu, M.D., Milton D. Vokes, M.D., Bruce C. Lockwood, M.D., and Edward Dowdle, M.D.

Mr. Speaker, I move that this portion of the report dealing with Life Memberships be approved.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—11(b). RETIRED MEMBERSHIP

There are twenty-two members of the Michigan State Medical Society who are recommended for Retired Membership, as follows:

Genesee County—Donald R. Brasie, M.D., and Bryce Miller, M.D.

Ingham County—Francis Jones, Jr., M.D., Harper D. Sichler, M.D., Henry E. Cope, M.D., and Robert M. Monfort, M.D.

Jackson County—David B. Sher, M.D.

Livingston County—A. J. Schenden, M.D.

North Central Counties—Paul J. Waltz, M.D.

Oakland County—Lynn F. Webber, M.D.

Shiawassee County—Elwood M. Chipman, M.D., Walter F. Shepherd, M.D., and Richard J. Brown, M.D.

Wayne County—L. Byron Ashley, M.D., John H. Buell, M.D., William S. Gonne, M.D., Edwin S. Hoffman, M.D., Gordon R. Knapp, M.D., Cyrus F. Oman, M.D., Eugene H. Payne, M.D., Peter B. Rastello, M.D., Irvin F. Sander, M.D., and Arthur P. Wilkinson, M.D.

Mr. Speaker, I move that this portion of the report be approved.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—11(c). ASSOCIATE MEMBERSHIP

A total of fifty-eight applications for Associate Membership are submitted herewith according to the accompanying lists.

Kent County—Ferdinand Valdmanis, M.D. [Military]

Oakland County—Joyce M. Carrow, M.D., and Arthur W. Weaver, M.D.

Shiawassee County—Jack R. Grommons, M.D.

Washtenaw County—Peter Aliferis, M.D., David C. Angell, M.D., Joseph M. Bicknell, M.D., Kenneth R. Bingman, M.D., Russell O. Briere, M.D., Garland R. Brown, M.D., Jorge A. Cabrera, M.D., James T. Cassidy, M.D., Joseph C. Cerny, M.D., Bruce E. Cohan, M.D., John W. Conwell, M.D., Juan V. Fayos, M.D., Gene T. Fries, M.D., William P. Haney, M.D., Beryl L. Harberg, M.D., Robert D. Hoag, M.D., Reiichi Izuka, M.D., David S. Jacobs, M.D., Charles M. Klein, M.D., John A. Lambie, M.D., David W. Learned, M.D., Benedict B. Lenhart, M.D., John F. McDermott, Jr., M.D., Margaret Meyen, M.D., Daniel B. Parsons, M.D., Burton L. Perry, M. D., Roger W. Postmus, M.D., Karl F. Schroeder, M.D., Ara A. Sheperdigian, M.D., Roger G. Thorpe, M.D., Charles H. Willingham, M.D., James P. Youngblood, M.D., Arthur B. Yull, M.D., and Joel P. Zrull, M.D.

Wayne County—Robert C. Dean, M.D. [Military], Charles Gitlin, M.D., Sidney Goldstein, M.D., Herbert H. Hagermoser, M.D., Arthur Isaacson, M.D., H. M. Kyprie, M.D., Alfred H. F. Lui, M.D., Thomas H. Murray, M.D., Rufus H. Parrish, M.D., and Marjorie R. Stewart, M.D.

It is not necessary to act on these Associate Memberships in the House of Delegates; this is merely for your information.

Mr. Speaker, I move that the report of the Reference Committee on Special Memberships be approved as a whole.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

TUESDAY MORNING SESSION

September 25, 1962

The fourth meeting of the House of Delegates reconvened at 9:10 a.m.

XIV—8. ON REPORTS OF SPECIAL COMMITTEES

XIV—8(b). ANNUAL AND SUPPLEMENTAL REPORTS OF THE COMMITTEE ON "CERTIFICATES OF COMMENDATION"

J. G. Slevin, M.D.: The annual report was reviewed and no change was recommended.

Mr. Speaker, I move the acceptance of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

J. G. Slevin, M.D.: The Supplemental Report of the Committee on "Certificates of Commendation" was reviewed, and it is recommended that a change be made in line 6, page 2, that now reads, "That any member of MSMS having a nominee considered worthy of this award should be urged to send his recommendation and listing of qualifications of such nominee to the Speaker of the House for reference to this Committee," by adding after "Speaker of the House" the words "through his component county medical society." And by amending the report, lines 9, 10 and 11, page 2, which read, "In order to prevent political pressures on the Committee from groups promoting a single individual, the personnel of the Committee should be kept secret throughout the year." Your Reference Committee recommends deletion of this sentence, in view of the screening which would be done by component county medical societies.

Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

J. G. Slevin, M.D.: Your Reference Committee considers that, to be effective, the selection for the Certificates of Commendation should be limited to a very small number each year, and so recommends.

Although this Reference Committee did not consider names of those chosen for Certificates of Commendation because the House took action on those candidates at its second session, your Reference Committee believes that the Committee on Certificates of Commendation should be commended by the House for the good judgment they exercised in the selection of candidates. It should be realized that this is the first time such a Committee has functioned. The Committee had no precedent to guide them.

Moreover, the task of choosing candidates for this Award was most difficult, due to a plethora of possible candidates. The fact that their choice was beyond reproach indicates that they labored diligently to be fair and impartial.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—8(c). ANNUAL REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON RELATIVE VALUE (1962 COMMITTEE)

J. G. Slevin, M.D.: Your Reference Committee finds that Dr. Miller's Committee discharged its duties in a very satisfactory manner as indicated in their report. The Committee caused to be conducted polls of county medical societies, and, of the fourteen that responded, all favored adoption of the Relative Value Study. The 1962 Committee therefore recommended adoption of the report of the Relative Value Study Committee made to the House of Delegates in September, 1961.

Your Reference Committee recommends adoption of this report, but with the advice that only that part of the report contained in the yellow booklet be used, from page 11 to page 72, inclusive, known as the Michigan Relative Value Study. Thus, this would eliminate any further publication of the Relative Value Study, pages 1 through 10. This material on pages 1 through 10 was background material.

Mr. Speaker, I move the adoption of this portion of the report.

The Speaker: The motion, then, is to approve the first paragraph in regard to the Relative Value Report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

J. G. Slevin, M.D.: Mr. Speaker, I move adoption of the second paragraph in this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

J. G. Slevin: Your Reference Committee then considered three resolutions which pertain to Relative Value.

XIV—8(d). RESOLUTION NO. 17

The Reference Committee submits a substitute resolution which reads as follows:

"Whereas, the report of the Relative Value Study Committee has been adopted; therefore, be it

"RESOLVED: That this action of the House pertaining to the Relative Value Study be referred to the Board of Directors of Michigan Medical Service for implementation as soon as practicable."

Mr. Speaker, I move the adoption of this substitute resolution.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—8(e). RESOLUTION NO. 27

The Reference Committee recommends that the first "Resolved" portion be amended to read:

"RESOLVED: That the Michigan Relative Value Scale be approved as the basis for negotiating the fee schedule with all governmental agencies and that the fee schedule for the average income group be used for such negotiations."

Also, the Reference Committee recommends that the second RESOLVED, which reads, "That the Michigan Medical Service be requested to use the Michigan Relative Value Scale in any and all contracts which the Michigan State Medical Society is expected to implement on a service basis," be stricken, inasmuch as this second RESOLVED is covered by Resolution No. 17.

Mr. Speaker, I move the adoption of Resolution No. 27 as amended.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—8(f). RESOLUTION NO. 49

Your Reference Committee recommends the adoption of this resolution with the following amendments in the RESOLVED portion.

Strike out "Michigan Blue Shield" and substitute "Michigan Medical Service"; strike out "directed" and substitute "requested"; strike out in the second line, after "unit value," the word "of" and substitute the word "for."

Thus, the "Resolved" portion would read:

"RESOLVED: That Michigan Medical Service be requested to provide readjustment at least every three years of the Monetary Unit Value for the Relative Value Schedule in response to (1) the changing cost of living, and (2) changes in the average fees charged outside of the plan."

Mr. Speaker, I move the adoption of this resolution as amended.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

J. G. Slevin, M.D.: Mr. Speaker, I move the adoption of this portion of the report as amended.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—8(a). ON ANNUAL REPORT OF COMMITTEE ON MEDICAL SOCIO-ECONOMICS

J. G. Slevin, M.D.: That part of the annual report of The Council which refers to medical socio-economics was reviewed by the Reference Committee.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—8(b). ON SUPPLEMENTAL ANNUAL REPORT OF MEDICAL SOCIO-ECONOMICS

J. G. Slevin, M.D.: The Supplemental Report of the MSMS Medical Socio-Economics Committee, which was presented at the first session of the House by Dr. Falls, was reviewed, and it is recommended that this report be adopted.

Mr. Speaker, I move the adoption of the Supplemental Report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

J. G. Slevin, M.D.: Your Reference Committee had the pleasure of hearing detailed reports by Professor C. T. Hardwick and Mr. Richard Campau on what has been done by the Department of Medical Socio-Economics in the first year of its existence.

Two examples of the value of this Department were presented, which your Reference Committee believes should be called to the attention of this House for its commendation as well as information.

The first example is that when members of MSMS appeared before the Governor's Commission on Prepaid Hospital and Medical Care, the Department provided such excellent background material that Medicine's cause was well defended.

The second example was when members of MSMS appeared before the Joint Committee of the House and Senate of the Michigan Legislature to show how the Michigan Uniform Fee Schedule for Governmental Welfare Agencies would work if applied to payments for medical fees under the Michigan Afflicted and Crippled Children laws. Again, the detailed economic information was most impressive and was well received by the members of the State Legislature.

Your Reference Committee believes that Dr. Falls and his Committee, as well as Mr. Campau, Professor Hardwick, and those members of the administrative staff of MSMS who worked with them in the establishment of this new Department of Medical Socio-Economics, should have the commendation of this House for fulfilling in a most excellent manner the intent of the House in the establishment of this Department. Not only is this a new Department but it is unique among state medical societies in the United States.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

J. G. Slevin, M.D.: Mr. Speaker, I move the adoption of the report of the Reference Committee on Reports of Special Committees in its entirety, as amended.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—4. ON MEDICAL SERVICE AND PREPAYMENT INSURANCE

XIV—4(d). RESOLUTION NO. 11

Don Marshall, M.D. [Kalamazoo]: The Reference Committee supports Resolution No. 11 in principle, but believes that to spell out in firm detail all desirable alterations implementing the Kerr-Mills law in Michigan requires careful study, more thorough than we were able to achieve. Therefore, we recommend that Resolution No. 11 be referred to the Medical Care Insurance Committee of The Council for consideration and implementation, with report to The Council.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—4(f). RESOLUTIONS NOS. 29 AND 42

DON MARSHALL, M.D.: Resolution No. 42 is entitled, "Implementation of the Kerr-Mills Act." Resolution No. 29 is entitled, "Change in Administrative Rules of Michigan Medical Aid to the Aged Act." We recommend acceptance of the principle of Resolution No. 29, have taken a portion of its last sentence for addition to Resolution No. 42, made minor changes, and recommend approval by this House of Resolution No. 42 as altered so as now to read:

"Whereas, the purpose of the Federal Kerr-Mils Act was to furnish medical assistance to the aged and not to provide care for welfare cases, and

"Whereas, the Michigan Medical Aid to the Aged Program is administered by the Department of Social Welfare through the Bureau of Social Aid in each county, and

"Whereas, the regulations of the Michigan Department of Social Welfare in effect nullify the intent of the Federal Kerr-Mills Act, and

"Whereas, if properly administered, the Michigan Medical Aid to the Aged Program would be beneficial to the public; be it therefore

"RESOLVED: That the administration of the Michigan Medical Aid to the Aged Program be made completely free and independent of the rules, regulations and policies of the Department of Social Welfare as applied to welfare cases, and that all payments for hospital service and medical care for MAA recipients be the fair and average fee for such services; and be it further

"RESOLVED: That the State Legislature be requested to enact appropriate regulations to fulfill the intent of this resolution; and be it further

"RESOLVED: That copies of this resolution be sent to each member of the Michigan Legislature."

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—4(e). RESOLUTION NO. 12

DON MARSHALL, M.D.: Resolution No. 12 is entitled, "Surgical Assistant's Fee." This problem as a Blue Shield benefit is more complex than might appear. We understand that at present Blue Shield will pay an assistant's fee only in a hospital not accredited for interns or residents. The Reference Committee considered the many facets of this problem. We did not change the intent of the resolution, but offer the following substitute Resolution No. 12, recommending its adoption:

"Whereas, the present practice of Michigan Medical Service, under certain circumstances, is to not allow a surgical assistant's fee, and

"Whereas, many hospitals do not have a full quota of interns and/or residents; therefore, be it

"RESOLVED: That the House of Delegates recommend to Michigan Medical Service that it pay a surgical assistant's fee where local circumstances in the hospital require additional help for the attending surgeon; and be it further

"RESOLVED: That such fee be paid only when a surgical assistant is needed and actual assistance is given."

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—4(g). RESOLUTION NO. 35

DON MARSHALL, M.D.: Resolution No. 35 is concerned with the Curtis Bill, H.R. 10117, which has passed the House of Congress. We change the second RESOLVED to read:

"RESOLVED: That MSMS urge the U. S. Senate to enact this legislation"

and recommend approval of this resolution as so altered.

Mr. Speaker, I recommend adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—4(h). RESOLUTION NO. 37

DON MARSHALL, M.D.: Resolution No. 37 is entitled, "Blue Cross Coverage for MSMS Widows and Families." Your Reference Committee recommends deletion of the ten words immediately following the second "Whereas," and otherwise the approval of Resolution No. 37 as printed.

Mr. Speaker, I recommend the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

R. R. COOPER, M.D.: May I ask that in the next line beyond that it be changed to "Blue Cross" instead of "Blue Shield"?

[*The motion was put to a vote and was carried unanimously.*]

XIV—4(i). RESOLUTION NO. 52

DON MARSHALL, M.D.: Resolution No. 52 is concerned with Blue Shield contracts for persons over age 65. Your Reference Committee recommends approval of this resolution with the following changes: The first paragraph is left as printed. The remainder will read as follows:

"Whereas, the principle of community rating is a traditional philosophy of Michigan Medical Service and is advisable to enable senior citizens to afford the contracts made available for them; therefore, be it

"RESOLVED: That this 1962 House of Delegates reaffirms that medical care for senior citizens over the age of 65 be continued and supported by Michigan Medical Service through the principle of community rating."

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—4(j). RESOLUTION NO. 56

DON MARSHALL, M.D.: Resolution No. 56 was sent to this Reference Committee. We recommend approval of this resolution as printed, with a change of the word "idea," near the end, to the word "objective."

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—4(b). ANNUAL AND SUPPLEMENTAL REPORTS OF THE HOUSE COMMITTEE TO STUDY THE ASSOCIATION BETWEEN MSMS AND MICHIGAN MEDICAL SERVICE

Your Reference Committee would change recommendation No. 2 to read as follows:

"(2) That the MMS Enabling Act and Articles of Incorporation continue to be adhered to, and that no change be made in the requirement that approximately two-thirds of the members of the Board shall be physicians."

With that minor change we recommend approval of this Committee report.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—4(c). ANNUAL AND SUPPLEMENTAL REPORTS OF THE COMMITTEE ON MEDICAL CARE INSURANCE OF THE COUNCIL

Don Marshall, M.D.: At the bottom of page 11, on the Composition of the Blue Shield Board of Directors, this Reference Committee supports the policy as expressed in the Articles of Incorporation, namely, that two-thirds of the Board members shall be physicians. We recommend that within that limitation the representation of the public on the Board shall be increased. With these minor changes we recommend for your approval this Supplemental Report of the Committee on Medical Care Insurance of The Council.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—4(a). ANNUAL AND SUPPLEMENTAL REPORTS OF MICHIGAN MEDICAL SERVICE

Don Marshall, M.D.: Under "Officers' Reports" you will find the July 20 report to The Council and Delegates of Sidney Adler, M.D., President of Michigan Medical Service, a review by MMS of action on some 1961 House of Delegates resolutions, and you later added the Supplemental Report by Dr. Adler given to this House Sunday night. These were all sent to this Reference Committee.

This Reference Committee has reviewed these reports with care. Additionally we have conferred with Dr. Adler, Mr. Sumner Whittier, and some members of the Blue Shield Board. This Reference Committee recommends receipt of the reports by Dr. Adler for information, and expresses its continued confidence in the Michigan Medical Service Board of Directors during this critical period in the further development of prepaid medical insurance.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

Mr. Speaker, I move the adoption of this Reference Committee's report as a whole.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

X—67. SPECIAL COMMENDATION TO WILFRID HAUGHEY, M.D., BATTLE CREEK

K. S. Wemmer, M.D. [Calhoun]: Whereas, Dr. Wilfrid Haughey has a long and distinguished record of service to the Michigan State Medical Society in numerous capacities and particularly as Editor of The Journal of the Michigan State Medical Society, and

Whereas, he has attended the House of Delegates meetings without interruption for nearly fifty years, and

Whereas, he is unable to be with us this year because of recent illness; therefore, be it

RESOLVED: That this House of Delegates express its cognizance of his absence and wish him a speedy recovery, and so notify him by telegram.

The Speaker: The Speaker would like to suggest that someone make a motion to suspend the rules so that we may consider this resolution at this time.

W. C. Beets, M.D.: I so move, Mr. Speaker.

[*The motion was severally seconded, was put to a vote, and was carried unanimously.*]

The Speaker: This resolution is now before you for discussion. Is there a motion to adopt the resolution by acclamation?

L. J. Bailey, M.D.: I so move.

[*The motion was severally seconded, was put to a vote, and was carried unanimously.*]

X—68. OPPOSE PASSAGE OF SB 3318 AND SIMILAR LEGISLATION

A. B. Levand, M.D. [Wayne]: Whereas, the tendency of government to give free medical and hospital care as "fringe" benefits for Federal Governmental service is unjustifiable in view of the tremendous number of citizens who work for the government, and

Whereas, coast and geodetic personnel are not part of the armed forces, and

Whereas, to provide free medical care for them would be setting a precedent for all other governmental employees; therefore, be it

RESOLVED: That the Michigan State Medical Society urge the American Medical Association to oppose the passage of S.B. 3318 or similar legislation which would provide medical care for coast and geodetic personnel and families at government expense.

The Speaker: This will be referred to the Reference Committee on Legislation and Public Relations.

XI—C. AWARDING OF "CERTIFICATES OF COMMENDATION"

The Vice Speaker: Jerome W. Conn, M.D., will you please step forward?

Born in 1907 in New York, Dr. Conn is a graduate of Rutgers University and the University of Michigan Medical School.

Instructor of Internal Medicine at the University of Michigan Medical School, 1935-1938. Assistant Professor of Internal Medicine, 1938-1944. Associate Professor of Internal Medicine, 1944 to present. Chief of Metabolism and Endocrinology, 1941 to present.

Distinguished as a medical investigator and teacher, his research has been in the broad field of endocrinology and metabolism. He is probably best known for the discovery of a new disease called "Primary Aldosteronism," also called "Conn's Syndrome." His research has dealt with other phases of adrenal cortical function, with climatological effects, with metabolic effects of various steroidal compounds, and with various aspects of diabetes and hypoglycemia.

Dr. Conn is noted for his teaching ability and for training younger colleagues who are now making contributions also to our knowledge in endocrine and metabolic diseases.

Dr. Conn has received many professional honors recognizing his work. These include the Banting Medal of the American Diabetes Association; the Claude Bernard Medal from the Institute of Experimental Medicine and Surgery at the University of Montreal; the Modern Medicine Award and Citation, the Henry Russell Lecture Award of the University of Michigan; the Gordon Wilson Medal of the American Clinical and Climatological Association, and Honorary Fellowship in the American College of Surgeons.

Dr. Engelke, I present to you Dr. Jerome W. Conn. [*Applause*]

President Engelke: Dr. Conn, the inscription reads:

"In recognition of his distinguished career in medical research and teaching. He is eminently known in research for his discovery of the new disease called 'Primary Aldosteronism' or 'Conn's syndrome.' Dr. Conn is highly respected as an outstanding teacher in the field of endocrinology and metabolism."

This is a great privilege, Dr. Conn. [*Applause*]

The Vice Speaker: G. D. Cummings, M.D., of Lansing, Michigan, will you step forward?

Born on October 20, 1904, Dr. Cummings is a graduate of the Massachusetts Institute of Technology and Wayne State University Medical School. He also holds a Ph.D. from the University of Michigan in Bacteriology.

Dr. Cummings began his association with the Michigan State Department of Health in 1926, serving as Junior

Bacteriologist, Senior Bacteriologist, Assistant Director, Associate Director, Acting State Health Commissioner in 1948, Director of the Division of Laboratories from 1944 to the present, and Associate Commissioner, 1957 to the present. He is now Associate Commissioner and Director of Laboratory Services.

Dr. Cummings is nationally recognized as an authority in preventive medicine and public health. He serves as Special Consultant to the Committee on Blood, Office of Emergency Planning, since 1957; International Consultant, Pan American Sanitary Bureau, World Health Organization, since 1956; Chairman of Research Committee, 1958-1959, State and Territorial Laboratory Directors; Consultant in Epidemiology and Public Health and Pediatrics at Edward W. Sparrow Hospital, Lansing, since 1944; Consultant, Department of Pediatrics at St. Lawrence Hospital, Lansing, since 1944. He also serves as a lecturer at both the University of Michigan and Wayne State University Medical Schools.

Recognition was accorded Dr. Cummings in 1961 when the Michigan Health Council Award was presented to him for "his outstanding achievements in public health as laboratory director."

The Michigan Society of Public Administrators in 1959 honored him with the Administration Career Service Award. He formerly served as Secretary of the Laboratory Section of the American Public Health Association, and has been active in many Michigan, national and international organizations.

Dr. Engelke, I present Dr. G. D. Cummings. [*Applause*]

PRESIDENT ENGELKE: This inscription reads:

"In recognition of his outstanding achievements in public health and laboratory research. He is a long-time associate in the Michigan Department of Health, serving now as Associate Commissioner, and continuing to distinguish himself as Director of Laboratory Services. One of his outstanding contributions has been the development of a blood fractionation program."

Congratulations, Dr. Cummings. [*Applause*]

THE VICE SPEAKER: Charles Stuart Kennedy, M.D., of Detroit, will you step forward, please?

Born on October 25, 1887, in Detroit. Graduate of the University of Michigan Medical School.

Following graduation he became associated with his father in the practice of surgery, and continued as his associate until 1926 when his father died. He has served Grace Hospital, Detroit, since 1913 as Chief of the Department of Surgery, and Vice Chief of Staff, 1938-1948, Chief of Staff from 1949 to 1952, and Chief Consultant at the present to the surgical staff. He is also Consulting Surgeon, Detroit Receiving, Herman Kiefer Hospitals, and the Haven.

Recognized as a master teacher, Dr. Kennedy first became associated with the old Detroit College of Medicine many years ago. He advanced in rank until he was Professor of Surgery at Wayne State University College of Medicine, serving as Acting Chief of the Department of Surgery during the World War II absence of the late Charles G. Johnston, M.D.

Dr. Kennedy was one of the Founders of the American Board of Surgery. He formerly served as Governor of the American College of Surgeons, and is a member too of the International Surgical Society.

Keenly interested in higher education and civic affairs, Dr. Kennedy is best known for his service as a Regent of the University of Michigan from 1945 until his resignation in 1961. He also is a Trustee of the Kresge Eye Institute, the Ty Cobb Foundation and the Brighton Hospital. He served as Library Commissioner from 1926 to 1945, and is a member of the Friends of the Detroit Library.

Dr. Engelke, I present Charles Stuart Kennedy. [*Applause*]

PRESIDENT ENGELKE: The inscription on the award is as follows:

"In recognition of his enviable record as a medical teacher and surgeon. He has been associated many years with Detroit hospital staffs in administrative positions, and is a respected master teacher of surgery. Dr. Kennedy has distinguished himself also in civic service, particularly as a Regent of the University of Michigan."

Congratulations, Dr. Kennedy. [*Applause*]

THE VICE SPEAKER: Robert L. Novy, M.D., of Detroit, will you step forward?

Born April 1, 1892. Graduate of the University of Michigan Medical School.

Dr. Novy has practiced internal medicine and cardiology in Detroit since 1919. He is Senior Physician and former Chief of Cardiology at Harper Hospital, and also is affiliated with Detroit Receiving, Herman Kiefer and Jennings Memorial Hospitals. He is Associate Professor of Clinical Medicine, Wayne State University.

Distinguished national pioneer in prepayment medical care plans, Dr. Novy was first elected to the Board of Directors of Michigan Medical Service in 1941. At that time, the newborn Michigan Medical Service was floundering in its own sea of generosity. He served seventeen years as a member of the Board of Directors and for thirteen years as its President, leading Michigan Medical Service to recognition as one of the outstanding Blue Shield plans in the nation.

When Dr. Novy resigned in 1955 from the Michigan Medical Service Board he was promptly elected President Emeritus. He was re-elected to the Board in 1959. Recognized too in national prepayment plan circles, Dr. Novy has just completed a term as a member of the American Medical Association Council on Medical Services. He is a former member of the Board of the National Association of Blue Shield Plans.

Dr. Novy has an outstanding record of service as a medical statesman. He is a former Chairman of the Wayne County Medical Society Board of Trustees; Wayne County Delegate to the Michigan State Medical Society, 1937-1962; "President for a Day" of the Michigan State Medical Society in 1954; Delegate to the American Medical Association for sixteen years, and formerly a member of the Detroit Board of Health for twenty-two years. He is a Past President of the Detroit Academy of Medicine and Past President of the Detroit Medical Club.

Dr. Engelke, I present to you Dr. Robert L. Novy. [*Applause*]

PRESIDENT ENGELKE: The inscription reads as follows:

"In recognition of his distinguished leadership to State and National Blue Shield Plans. He was President of Michigan Medical Service for thirteen years, and has given even longer service to the Michigan Medical Service Board of Directors. Dr. Novy is an outstanding medical statesman in his county, State and national Medical Societies."

Congratulations, Bob. [*Applause*]

And now, I think it would be entirely proper if we gave a rising ovation to these first four recipients of this award.

[*The audience arose and applauded.*]

THE SPEAKER: On behalf of the House of Delegates I want to add my acclaim to these four men of medicine.

TUESDAY EVENING SESSION

September 25, 1962

The fifth meeting of the House of Delegates reconvened at 8:15 p.m., J. J. Lightbody, M.D., Speaker, presiding.

XV. GENERAL MEETING OF THE MICHIGAN STATE MEDICAL SOCIETY

PRESIDENT ENGELKE: The Constitution of the Michigan State Medical Society calls for a meeting of the membership at this time. The principal order of business at this session is the installation of your new President.

The Michigan State Medical Society will face many difficult situations in this coming year. I can think of no one better qualified to lead the Society than Dr. Clarence Owen, who will be installed as President this evening. His personal attributes, his record in the practice of medicine, his record as a member and officer of the Wayne County Medical Society and in the Michigan State Medical Society, and his record as a Delegate to the American Medical Association, as well as many other activities, all point to an excellent administration.

At this time I would like to ask Dr. Martmer, of Wayne, and Dr. Lynn, of Delta, to escort Dr. Owen to the platform, please.

[*The audience arose and applauded.*]

PRESIDENT ENGELKE [*continuing*]: Dr. Owen, we are all confident that yours will be a brilliant administration. I pass on to you this Medal as a symbol of the installation procedure.

Members, Ladies and gentlemen, may I present your new President of the Michigan State Medical Society and chairman of this session, Dr. Owen. [*Applause*]

[*Dr. Clarence I. Owen assumed the Presidency.*]

PRESIDENT OWEN: It is hard enough to follow you in office, Otto, and in listening to that introduction I wondered who the guy was you were talking about. You have made it tough for me.

I am supposed to make a few remarks, so you will have to put up with me.

Mr. President, Members of the Michigan State Medical Society, Distinguished Guests, Ladies and Gentlemen:

It is with a mixture of humility and, of course, a certain amount of pride that I assume the office of President of this great organization, the Michigan State Medical Society. Not only is this a great organization, but it is the unit in the State of Michigan of one of the oldest and most honored professions in the history of man.

The medical profession of the United States and the State of Michigan has much of which to be proud. The American system of medical practice has developed and is furnishing the finest medical care the world has ever seen. Our people are healthier and live much longer than they did a generation ago. Among the major reasons responsible for this change are the decrease in infant mortality, the sharp decrease of maternal mortality, and the marked reduction and almost complete disappearance of many of the infectious and communicable diseases. The latter has been so pronounced that recently one case of smallpox found in a traveler in New York City threw the newspaper and transportation worlds into consternation. A generation ago this would have passed unnoticed.

Many of our accomplishments have created new problems. For example, the decrease in maternal mortality and in infant mortality has encouraged and resulted in the production of larger families. The increased longevity in the population has resulted in more older people. Life expectancy is now over 70 years. These changes, which have been produced by our good accomplishments and work, are responsible to a great extent for some of the political and social problems that are giving us so much concern.

From a social standpoint, the medical profession always has had a strong conscience. The amount of charity and semi-charity work done by doctors of medicine is tremendous. Actually the total is unknown. One never hears a physician boasting about the amount he has done.

In order to keep medicine free and independent of government and state control, the profession has been obliged to be more active on the political scene, and lately has been successful on a national as well as a state level. We, as a profession, must be and are constantly on the alert for scientific advancements that can be applied to the practice of medicine. We, likewise, must be alert to social and political situations that would influence the practice of medicine.

Since our country has the best medical care in the world, which has evolved under a system of private practice, it follows that those countries which have socialized medicine and medicine under government control must have made some mistakes down the line somewhere. It is our duty from a political standpoint to be always on the alert to advise the public and to use our influence to keep the type of medical practice and service which has proven so satisfactory.

We must be fully aware of the large number of politicians and other so-called leaders in positions of trust who are more interested in power and spoils of office than in the furnishing of sound leadership. These are the type of idividuals who are generous with the "other people's" money and services and who would even give away the services of our profession.

We must insist on top-quality medical care, and we must strive always for perfection in the administration of that care. We must not allow certain politicians or opportunists, who are not in the medical field, to set themselves up as so-called experts. Too many such people are happy only when they are harassing business and/or the professions. We wonder whether they are really interested in the people and in good medical care or whether their real objective is personal power.

Our activity and recent successes in State and national legislative circles must be treated with humility and understanding. We must not be complacent, but must be on the alert for new moves by our adversaries. We must be willing as individuals and as an organization to support those candidates for office who believe in those principles that have helped make America and American medicine great.

I would encourage members of our profession to participate in politics by being candidates for public office. At the present time there are no doctors of medicine who are members of the State Legislature of Michigan. There are six who are members of the House of Representatives in Washington. Doctors of medicine in our Legislature and a larger number in the Congress would be to the advantages of the public at large because a sound medical viewpoint is needed on many pieces of legislation.

It is our responsibility to help keep the public informed about the dangers of welfare and dictator states under whose ægis the medical profession is placed at a disadvantage. Cuba lost thousands of their doctors of medicine after Castro became dictator. Great Britain is losing native-born physicians who are being replaced by colonials. The province of Saskatchewan in Canada will be a long time recovering from the fracas that took place last summer.

It is our duty to be socially conscious. We should promote those things which we believe will help to preserve our private practice system. Likewise, we must always protect our freedom in thinking and in the application of medical science. Our great danger in this respect is the bartering of our services by third-party agents without our consent or with only our reluctant or qualified consent.

In the area of providing needed medical care for all, we must strive to make the voluntary prepaid medical care plans work to their maximum. Our profession in

Michigan sponsored and encouraged the Michigan Medical Service, of which we can truly be proud. Michigan is one of the few states in the Union that has a single Blue Shield organization covering the entire state. Many states have two or more separate organizations, which tends to make for confusion and misunderstanding.

We must remember always that our profession is a profession of service—service of ourselves, service of our knowledge, and service of our professional ability. Some very notable medical services have been performed the world over in the last few years by American doctors such as Tom Dooley.

To come close to home, I could talk at length about my good friend, Dr. John Ormand, who practices in Pontiac. About ten years ago John retired from a busy practice in Detroit. He spent the following two years in India, where he established residencies in his specialty and set up a department of urology in a medical school. After two years and a tremendous amount of personal satisfaction, John returned to Pontiac to resume a practice.

Practically every religious denomination offers the privilege of service in foreign fields for periods of from six months to two years. Some offer tours as short as thirty days. What better vacation could a physician have from the modern turmoil and worries of practice? He could return after such a period refreshed with the knowledge that he had given of himself, and with a renewed vigor in his work.

The Project HOPE, sponsoring the hospital ship *SS Hope,* is a worthy enterprise, and one in which doctors of medicine can, and do, serve to good advantage. Several of our own members have participated with dictinction, and some are probably in this room tonight. Cash contributions from doctors of medicine to medical missions and to Project HOPE have been put to good use.

Dr. Rawlings of Flint is here. He has the latest information on Project HOPE. He has pamphlets and can tell you all about it. Doctors do more than serve; they even try to find other people to go along, such as dietitians and nurses.

We can serve effectively at home in many ways. I would strongly recommend that you support the politically-oriented organization known as AMPAC nationally, and Minutemen in our State, and by other names in other counties. I would urge also that you support the American Medical Association Education and Research Fund. This is a noble project that has been serving nationally in the assistance of medical education by direct grants to deans of medical schools, and by loans and scholarships to worthy medical students.

We must do our work and perform our services with enthusiasm, from the depth of our heart and without personal fanfare. This is best expressed in "The Vision of Sir Launfal," by James Russell Lowell: "Not what we give, but what we share, for the gift without the giver is bare."

We must also furnish strong and certain leadership—leadership that will take responsibility and give direction. These and many other things we must do with sincerity and with purpose.

The Doctor of Medicine image is good. We must work to keep it good. We have the opportunities to do this today through our component medical societies, through the Michigan State Medical Society, through the American Medical Association, and through many worthwhile community organizations.

This is a personal challenge to all of us. No one else can do it for us. We must take personal interest. Together we must continue our dedicated service to our fellow men. [*Applause*]

Now, Otto, will you come front and center? Otto, it is with pleasure that I succeed you in this office. I only hope I will be half as effective as you.

As a "prize" for all of your work, may I give you this pin. In addition, may I present to you this scroll, which reads: "Presented by the Michigan State Medical Society to Otto K. Engelke, M.D., President, 1961-1962. In deep appreciation and grateful recognition of distinguished service rendered to medicine." This is signed by D. Bruce Wiley, M.D., Secretary, and O. B. McGillicuddy, M.D., Chairman of The Council.

I hope you will hang this in your study and that it will be a pleasant reminder of the days when you did all that hard work. [*Applause*]

O. K. Engelke, M.D.: I want to thank each and every one of you for the opportunity to serve the people of the State of Michigan. I want to tell you, Clarence, that with a group of men like this behind you, your problems will not be too great.

The difficulty of a president serving an organization like this is not in finding talented people to do the work, but it is the business of selecting from among so many talented people without offending other good friends.

Thank you again.

[*The audience arose and applauded.*]

XIV—3. ON LEGISLATION AND PUBLIC RELATIONS

XIV—3(a). RESOLUTION NO. 1

M. R. Weed, M.D.: Your Reference Committee considered Resolution No. 1—Medical Care Insurance—was approved in principle. For clarity the first Resolved was rewritten to read as follows:

"RESOLVED: That the Michigan State Medical Society support the principle of partial government subsidy of privately administered prepaid medical care through the medium of income tax credit for individuals below a defined income tax level or subsidy in full for eligible persons whose income is below a taxable level; and that benefits for the latter group under such insurance contracts be those normally provided for the average income group in the area in which they reside; and be it further

In the second Resolved, the words "United States" were inserted before the word "Senators" in the third line, and will read as follows:

"RESOLVED: That the Michigan State Medical Society present this resolution to the American Medical Association and that copies be forwarded to the United States Senators and Representatives from Michigan."

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—3(m). RESOLUTION NO. 34

M. R. Weed, M.D.: Resolution No. 34—Internal Revenue Mechanisms—was considered. The Reference Committee recommends commendation for Representative Johansen of Michigan for the introduction of H.R. 9387 which includes the principle of income tax deduction in payment of health care insurance for the elderly, but recommends that no action be taken on this resolution.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—3(b). RESOLUTION NO. 4

M. R. Weed, M.D.: Resolution No. 4—Education of Registered Nurses—was approved in principle and modified to read as follows:

Whereas, there has been a shortage of nursing personnel for many years, and

"Whereas, in the future a far greater demand for nursing personnel of all classifications is anticipated, and

"Whereas, some colleges and universities will accept for training in basic sciences only nurses enrolled for a degree, and

"Whereas, some schools of nursing which graduate registered nurses are having difficulty in obtaining cooperation on the part of such colleges and universities to educate their students in the basic sciences, and

"Whereas, registered nurses are urgently needed; therefore, be it

"RESOLVED: That tax-supported colleges and universities make available to nursing schools basic science courses for training student nurses; and be it further

"RESOLVED: That the Michigan State Medical Society recommend to the Michigan State Legislature that tax-supported schools be requested to furnish such basic science courses."

The Reference Committee recommends adoption of this resolution as amended.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—3(c). RESOLUTION NO. 5

M. R. Weed, M.D.: The Reference Committee approved this resolution but amended the last Resolved, in the interest of consistency with other resolutions presented, to read:

"RESOLVED: That a copy of this resolution be transmitted to each member of the Michigan Legislature elected in the November 1962 State election."

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—3(n). RESOLUTION NO. 36

M. R. Weed, M.D.: Resolution No. 36—Extending Good Samaritan Legislation—was considered and approved with slight modification.

In the third Whereas, second line, the words "under these" were deleted and the words "resulting from such" were inserted. In the Resolved paragraph, fourth line, the words "severe natural" were deleted and the word "widespread" substituted. The amended "Resolved" portion will read:

"RESOLVED: That this House of Delegates direct the Committee on Legal Affairs to strongly urge the Legislature to add appropriate immunity from subsequent malpractice action for medical personnel who are required to render their professional services under adverse conditions created by enemy attack or widespread disaster."

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—3(d). RESOLUTION NO. 14

M. R. Weed, M.D.: Resolution No. 14—Protective Health Measures for Boxers—was approved with the following minor changes. In the first Whereas, the words "thus far" were inserted after the word "occurred" in line 1, and the second Resolved was amended to read:

"RESOLVED: That a copy of this resolution be furnished each member of the Michigan Legislature elected in the November 1962 State election."

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—3(e). RESOLUTION NO. 16

M. R. Weed, M.D.: Resolution No. 16—Single Medical Practice Act—was approved in principle. The Resolved was amended to read:

"RESOLVED: That this matter be referred to The Council of the Michigan State Medical Society for further study."

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—3(g). RESOLUTION NO. 20

M. R. Weed, M.D.: Resolution No. 20—Single Medical Practice Act—was considered. In view of the fact that no suitable definition of "a single medical practice act" was presented, the Reference Committee recommends no action on this resolution at this time.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—3(f). RESOLUTION NO. 19

M. R. Weed, M.D.: Resolution No. 19—Function of Public Health Service—was approved in principle and revised to read as follows:

"Whereas, the function of the various public health services, national, state, county and local, is the control of contagious diseases, environmental sanitation, the protection of the public against communicable diseases by various means, the compilation of vital statistics, the provision of public health education and information, the investigation of the spread of disease, and the suppression of epidemics, and

"Whereas, diagnosis and treatment of such diseases as diabetes, cardiovascular disease, malignancy, and mental illnesss do not fall, therefore, within the purvue of such public health services; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society strongly opposes, as being contrary to the best interests of the public, the encroachment by these public health services upon those fields of medicine especially mentioned or any field of medicine not specifically and directly the concern of such public health services; and be it further

"RESOLVED: That this resolution be referred to The Council of the Michigan State Medical Society for further study."

Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded.*]

[*The motion was put to a vote and was carried unanimously.*]

XIV—3(h). RESOLUTION NO. 25

M. R. Weed, M.D.: Resolution No. 25—Immunity from Legal Entanglements When Drawing Blood Samples. The Reference Committee considered with sympathy the motivation for the submission of this resolution, but in consultation with Mr. Dodd, Legal Counsel of the Michigan State Medical Society, was convinced that no further legislative action is needed in this area, and therefore recommends no action on this resolution.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—3(j). RESOLUTION NO. 28

M. R. Weed, M.D.: Resolution No. 28—Endorsement of House Bill 39—1962 Regular Session, Michigan State Legislature—was approved with the following minor amendments:

The first and second Whereases were transposed and the second Resolved was amended to read:

"RESOLVED: That this House of Delegates urge that the Governor of Michigan, by signing such a bill into law, assure legislation by properly enacted statute rather than by administrative fiat."

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—3(k). RESOLUTION NO. 30

M. R. Weed, M.D.: Resolution No. 30—Health Insurance Pooling. The Reference Committee was in sympathy with the intent of this resolution. After consultation with Mr. Noel Sanborn, of the Health Insurance Institute of America, certain modifications were made in the resolution.

The Reference Committee recommends adoption of the amended resolution which reads as follows:

"Whereas, successful plans have been developed and are now in operation in Connecticut and Massachusetts, and are under consideration in several other states, to provide for the 'pooling' of high risk groups covered by health insurance, thus making possible the offering of coverages of greater adequacy at less cost to subscribers of such high risk groups, and

"Whereas, the concept of 'risk pooling' has proved sound in application to automobile insurance, and

"'Whereas, in those areas where it is now in operation in the health insurance field it has proved of great value to the elderly and others, and

"Whereas, it is necessary for the Michigan statutes to be changed to permit private, voluntary health insurance companies in this State to adopt similar programs; therefore, be it

"RESOLVED: That The Council of the Michigan State Medical Society as soon as possible study the advisability of requesting the Michigan State Legislature to enact suitable enabling legislation to permit the creation of health insurance pooling plans in this State."

Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—3(o). RESOLUTION NO. 43

M. R. Weed, M.D.: Resolution No. 43—Cash Return from Social Security. The Reference Committee was in sympathy with the intent of this resolution. It recommends adoption of this resolution rewritten to read as follows:

"Whereas, the Social Security program of the Federal Government has always paid cash benefits to those qualifying, and

"Whereas, any change in the basic principle of Social Security which would substitute service benefits for cash benefits would create a precedent leading to demoralizing paternalism; therefore, be it

"RESOLVED: That the Michigan State Medical Society hereby express its opposition to the substitution of services for cash benefits under the Social Security program; and be it further

"RESOLVED: That this resolution be forwarded to the Secretary of Health, Education and Welfare and to all U. S. Senators and Representatives from the State of Michigan."

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—3(p). RESOLUTION NO. 44

M. R. Weed, M. D.: Resolution No. 44—Favoring Recognition of General Hospitals of Realistic Size. The Reference Committee approved this resolution in principle and recommends its adoption modified to read as follows:

"Whereas, the Governor's Commission on Prepaid Hospital and Medical Care Plans, in Recommendation No. 12, has 'recommended that the minimum acceptable size for acute general hospitals should be set at fifty beds,' and

"Whereas, such a restriction on acceptable size would discriminate against the citizens of smaller communities who desire to support general hospitals of size appropriate to their needs; therefore, be it

"RESOLVED: That the Michigan State Medical Society herewith express its opposition to this Recommendation No. 12 of the Governor's Commission, and that this resolution be transmitted to The Council of the Michigan State Medical Society for implementation."

Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried, with one "No" vote.*]

XIV—3(q). RESOLUTION NO. 46

M. R. Weed, M.D.: Resolution No. 46—Psychiatrists on the Mental Health Commission. The Reference Committee approved this resolution with one minor amendment—the deletion in the Resolved section, third line, of the word "practicing" and the substitution of the word "qualified."

Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded.*]

[*The motion was put to a vote and was carried, with one "No" vote.*]

XIV—3(r). RESOLUTION NO. 50

M. R. Weed, M.D.: Resolution No. 50—Opposing Health Care Advisory Committee to the State Insurance Commissioner. The Reference Committee was in sympathy with the intent of this resolution, but since it felt that it would not be advisable to take positive action upon this matter at the present time, it recommends that this subject be studied by The Council for action at an appropriate time.

Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—3(s). RESOLUTION NO. 55

M. R. Weed, M.D.: Resolution No. 55—Opposition to Enlargement of Governmental Activities in the Practice of Medicine. The Reference Committee approved this resolution in principle and recommends adoption of this resolution, revised to read as follows:

"Whereas, there is a growing tendency on the part of the Federal Government to invade the practice of medicine through the enlargement of the jurisdiction of federal agencies, and

"Whereas, the government can best serve the people by carrying out the present responsibilities which these agencies have without enlarging their scope of activities; therefore, be it

"RESOLVED: That the Michigan State Medical Society go on record as opposing the enlargement and extension of Federal Governmental responsibilities in the health fields."

Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—3(t). RESOLUTION NO. 59

M. R. Weed, M.D.: Resolution No. 59—Unemployment and Workmen's Compensation Acts. The Reference Committee approved this resolution as submitted.

Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—3(u). RESOLUTION NO. 68

M. R. Weed, M.D.: Resolution No. 68—Provision of Medical Care for Coast and Geodetic Personnel and Their Families. The Reference Committee approved this resolution as submitted.

Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—3(i). RESOLUTION NO. 26

M. R. Weed, M.D.: Resolution No. 26—Proposed Institute of Child Health and Human Development.

The Reference Committee was unable to secure sufficient information about the provisions included in H.R. 11099, referred to in the resolution, and therefore had insufficient information to make a justifiable decision on this resolution. It therefore recommends no action at this time.

Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—3(l). RESOLUTION NO. 32

M. R. Weed, M.D.: Resolution No. 32—Social Security Taxes. The Reference Committee was unable to secure information as to the provisions of House Joint Resolution No. 673, referred to in the resolution, and therefore had insufficient information to make a justifiable decision on this resolution. It therefore recommends no action at this time.

Mr. Speaker, I move adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XIV—3(v). THE PRACTICE OF PHARMACY BY CORPORATIONS

M. R. Weed, M.D.: "The Practice of Pharmacy by Corporations." Supplemental Annual Report of The Council, September 23, 1962, page 18. The Reference Committee reviewed this portion of the report of The Council and prepared and approved the following resolution. Resolution No. 69 was presented.

In our deliberations it became obvious that proper consideration of a number of the resolutions was hampered by the lack of sufficient factual information, particularly in reference to bills pending before various legislatures, which might have been supplied by sponsors of the resolutions or their representatives.

The Reference Committee would therefore recommend that in all cases sponsors of resolutions appear before the reference committee considering their resolution, or designate representatives to do so. When reference is made to pending legislation, copies of such billls should be made available to the reference committee.

Mr. Speaker, I move adoption of the report as a whole.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

R. E. Wunsch, M.D.: Mr. Speaker, I move a special vote of thanks to this Reference Committee for their excellent work. They have done a tremendous job. [*Applause*]

X—69. OWNERSHIP AND LICENSURE OF PHARMACIES

J. W. Rice, M.D. [Jackson]:

Whereas, it has come to the attention of the Michigan State Medical Society that a national grocery store chain is attempting to procure licenses to operate pharmacies in connection with chain groceries through the technique of acquiring ownership of an existing corporation which is protected under the "grandfather clause" of the Michigan statute governing the ownership of pharmacies, and

Whereas, the medical profession believes strongly that it is not in the public interest, and does in fact present a definite threat to the health and welfare of the public to permit drugs to be dispensed to the public through pharmacies, so owned and operated; therefore, be it

RESOLVED: That the Michigan State Medical Society go on record as vigorously opposing any extension of the practice of licensing the sale or dispensing of drugs by and through corporate pharmacies which are not principally owned and operated by registered pharmacists.

M. R. Weed, M.D.: Mr. Speaker, I move adoption of this resolution.

[*The motion was duly seconded. The motion was put to a vote and was carried unanimously.*]

XIV—12. ON WAYS AND MEANS

R. V. Taylor, M.D.: The Councilor Advisers, Dr. Oliver B. McGillicuddy and Dr. Warren W. Babcock, spent considerable time in a review of the financial position including the detailed budget analysis of the Michigan State Medical Society.

The Reference Committee found the material extremely valuable and instructive, and commends the Finance Committee for its efforts.

Inasmuch as the Reference Committee on Ways and Means is to be responsible for arrangements to finance all projects which may not fit within the Michigan State Medical Society budget, the Reference Committee therefore recommends that the report of the Finance Committee of The Council be annually referred to the Reference Committee on Ways and Means of the House of Delegates, and that the detailed financial position and budget of the Michigan State Medical Society be supplied in advance of the Annual Session to each member of the Reference Committee on Ways and Means.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

R. V. Taylor, M.D.: The Reference Committee also recommends that any proposed resolution submitted to the Michigan State Medical Society House of Delegates which might involve unbudgeted expenditures should be referred simultaneously to the appropriate reference committee and also to the Reference Committee on Ways and Means.

Mr. Speaker, I move the adoption of this portion of the report.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

R. V. Taylor, M.D.: A review of the 1960 Resolution No. 24, entitled "Employee Recognition," approved by the House of Delegates, was requested by The Council in their report to this House of Delegates. The report of The Council was referred to the Reference Committee on Reports of The Council, and the question concerning

Resolution No. 24 was subsequently referred to the Reference Committee on Ways and Means.

It was the unanimous opinion of this Reference Committee that employee recognition, to be significant, must be cumulative as to tenure of service, and the Reference Committee recommends adoption of this policy by the House of Delegates.

Mr. Speaker, I so move.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

Mr. Speaker, I move approval of the report of the Reference Committee on Ways and Means as a whole.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XVII. ELECTIONS

XVII—1. COUNCILOR FROM THE 1ST DISTRICT

J. G. Slevin, M.D.: I nominate Dr. D. W. McLean of the 1st District.

R. E. Wunsch, M.D.: I second the nomination.

G. S. Fisher, M.D.: I move that nominations be closed.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XVII—2. COUNCILOR FROM THE 7TH DISTRICT

K. T. McGunegle, M.D.: I nominate Dr. John Coury, who has done an excellent job.

W. J. Dinnen, M.D. [St. Clair]: I second the nomination of Dr. Coury.

The Vice Speaker: Are there further nominations from the floor? Since we have only one candidate, I will invite the pleasure of the House. All those in favor of Dr. Coury, say "aye"; opposed, the same sign. It is carried unanimously.

XVII—3. COUNCILOR FROM THE 8TH DISTRICT

V. V. Bass, M.D. [Saginaw]: As Dr. Oldham has expressed a desire not to continue as Councilor, it is my pleasure to nominate Dr. A. Carl Stander of Saginaw as Councilor for the 8th District.

H. L. Gordon, M.D. [Midland]: I would like to second the nomination of Dr. Stander.

The Vice Speaker: Are there further nominations from the floor for this particular office?

J. L. Leach, M.D. [Genessee]: I move that nominations be closed and that Dr. Stander be elected by acclamation.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XVII—4. COUNCILOR FROM THE 10TH DISTRICT

W. G. Gamble, M.D. [Bay-Arenac-Iosco]: I would like to place in nomination the name of Dr. David A. Bowman, of Bay City.

J. W. Bunting, M.D. [Bay-Arenac-Iosco]: Second the nomination.

L. F. Hayes, M.D.: I move that nominations for Councilor of the 10th District be closed and that he be elected by acclamation.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

The Vice Speaker: Dr. Bowman is the new Councilor for the 10th District.

XVII—5. DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

R. R. Cooper, M.D.: It gives me great pleasure to place in nomination the name of the President of our Society, Dr. Clarence I. Owen.

H. W. Devine, M.D. [Wayne]: I would like to support the nomination of Dr. Owen.

E. J. Tallant, M.D.: I nominate Dr. Donald N. Sweeney, Jr.

L. F. Segar, M.D.: I second the nomination of Dr. Sweeney.

K. S. Wemmer, M.D. [Calhoun]: It is with pleasure that I nominate, to succeed himself as delegate to the AMA, Dr. George W. Slagle.

C. W. O'Dell, M.D. [St. Joseph]: I would like to second the nomination of Dr. Slagle.

The Vice Speaker: Are there further nominations from the floor?

R. E. Wunsch, M.D.: I move that nominations be closed.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

XVII—6. ALTERNATE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

E. M. Vardon, M.D.: I would like to place in nomination the name of Dr. Edgar E. Martmer, of Wayne County.

W. C. Beets, M.D.: I would like to nominate Dr. Robert E. Rice.

D. W. McLean, M.D.: I have known Ed Martmer since prep school days when he and I were students together. I would like the opportunity of making a little fancier second of his nomination.

As you know, he is a pediatrician of national repute. He is a former President of the American Academy of Pediatrics, and it was largely through his efforts that the Academy has reached the high place it now holds.

At present Dr. Martmer is a valued member of our State Council, and his many years of service to the County Society have always been of the highest order. Gentlemen, it gives me great pleasure to second the nomination of Edgar Martmer for alternate delegate to the American Medical Association.

W. C. Beets, M.D.: I would like to nominate Dr. R. E. Rice to succeed himself.

J. A. Ferguson, M.D.: I would like to second the nomination of Bob Rice.

W. J. Yott, M.D.: Dr. A. Hazen Price is an internist who has been an active partner and in active practice in the City of Detroit for many years. He has been a hospital and medical school teacher, and has been very active in the State and County Medical Societies. A recent accomplishment was his defeating me in nominations of the Wayne County delegates for alternate delegate to the AMA. It gives me great pleasure to nominate Dr. A. Hazen Price as alternate delegate to the American Medical Association.

Alexander Blain, M.D.: I also have gray hair, and Dr. Price was my teacher, too; but he is younger than I am. I would like to second his nomination.

The Vice Speaker: Are there further nominations from the floor? If not, what is your pleasure?

G. S. Fisher, M.D.: I move that nominations be closed.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

The Vice Speaker: I now invite you to take your first ballot and vote for these men in the order of your choice.

[*Balloting.*]

XVII—7. PRESIDENT-ELECT

D. A. Bowman, M.D. [Bay-Arenac-Iosco]: Mr. Speaker and gentlemen, I would like to place in nomination the name of a friend of mine. I won't go into too much of his history.

He has served in this House for many years. He has

served as a delegate to the AMA and as Vice Chairman of The Council. He has been on many medical societies. He has been president of his local medical society and chief of staff of both hospitals and Chief of the Surgery Section in both hospitals in his home town. He is Editor of the Bulletin. His other community functions are too numerous to mention.

I would like to place in nomination the name of Dr. Orlen J. Johnson for President-elect, and say that this man has contributed great value to his community and to this State Society, and will make a President of whom we will all be proud.

Thank you. ([*Applause*]

J. W. Bunting, M.D.: Mr. Speaker, I represent all of Northern Michigan. Dr. Johnson has served us very well, faithfully and kindly and intelligently. We support him very strongly.

The Vice Speaker: Thank you very much. Are there further nominations from the floor? What is your pleasure, gentlemen?

L. F. Hayes, M.D.: There being no further nominations for President-elect, I move that nominations be closed and that the unanimous ballot be cast for Dr. Johnson. [*Applause*]

[*The motion was severally seconded, was put to a vote, and was carried unanimously.*]

[*Doctor Johnson was escorted to the rostrum.*]

O. J. Johnson, M.D.: Mr. Speaker, Mr. President, Members of the House of Delegates and Friends:

Two years from tonight I shall occupy this podium in my final action as your retiring President. In the next two years, I shall do everything within my power to discharge with credit the duties and honor that you have given me.

For over twenty years of actual participation in this medical organization, I have been proud and impressed by the devotion, diligence and decisions of the House of Delegates on matters scientific and otherwise upon which they deliberated. There are many medical organizations serving the special interests of scientific groups, but there are none that serve all the interests, both professional and scientific, of all physicians as do your county and State Society and the AMA.

I charge the members of the House of Delegates as officers of this Society to conduct programs and elect officers who will strengthen the effectiveness of medical organization activity. The small or specialty medical groups, while serving their constituents to great advantage, can, unless care is exercised, undermine or discredit programs designed to serve the total public and the total profession.

In my opinion, these groups can still render valuable service to their members; and indeed can better serve them and at the same time aid all doctors of medicine by integrating their plans and activities with the basic objectives, policies and programs of county and state societies and the American Medical Association.

We know we are assaulted from without. Think well and long lest we be weakened from within. Make your local society strong. Actively support your President, Dr. Clarence Owen, Chairman McGillicuddy and The Council as a whole, so that twenty years from tonight we can be proud of ourselves in maintaining our goal of continuity of the best medical care for our patients.

XVII—8. SPEAKER

G. T. Bradley, M.D. [Wayne]: Mr. Vice Speaker, I would like to place in nomination the name of our very efficient incumbent, Dr. James Lightbody.

W. C. C. Cole, M.D. [Wayne]: I second the nomination of Dr. Lightbody.

L. A. Drolett, M.D.: I would like to support the nomination of Dr. Lightbody for Speaker of the House.

The Vice Speaker: Are there other nominations?

R. E. Wunsch, M.D.: Mr. Vice Speaker, because there are no other nominations, I would like to move that nominations be closed and that the Secretary cast the unanimous ballot. [*Applause*]

[*The motion was severally seconded, was put to a vote, and was carried unanimously.*]

The Speaker: All I can say is thanks again. I had sincerely hoped that Harold Falls would continue as he has in the past, as Vice Speaker and Speaker. He has decided not to do this because he has a great many other duties to perform. I know how he feels about it. He would like to continue, but he has other things to do that to him seem more important. Perhaps they are.

He has been a great help to me during the past two years, and at times it may seem easy to do what we do up here. The only reason it seems easy is because of the way you gentlemen act out there in front. I know you could make it very difficult for us up here, but I am sure you try to help us. Once in a while somebody gets off the beam and makes it a little difficult, but as a rule we don't have too much trouble.

At this session we haven't had too many amendments to amendments, and not very many things have been tabled. A few things have gone on under the table, but they didn't bother us. [*Laughter*]

I do want to thank you sincerely. I sat out there in front for a good many years before I sat up here. What I am trying to do in the House is to make things pleasant for you during your days of deliberations, because you take a number of days out of your busy lives to come here and discuss the problems that we think are very important. I am sure all the other doctors in this State appreciate the time that you devote to this job.

Thank you very much. [*Applause*]

XVII—9. VICE SPEAKER OF THE HOUSE

H. A. Scovill, M.D.: Mr. Speaker, it gives me great personal pleasure to place the name of John Wesley Rice, of Jackson County, in nomination as Vice Speaker of this House. Dr. Rice is well known to you. He has served on many important committees of the House. At the present time he is serving on at least seven committees of our State Society.

Dr. Rice has served this House with distinction and faithfulness, and has shown the qualities of leadership and judgment necessary for this important office.

R. M. Bookmyer, M.D. [Oakland]: Mr. Speaker, I would like to second the nomination of that very dedicated man, Dr. Rice.

F. C. Brace, M.D. [Kent]: Mr. Speaker, I also would like to second the nomination of one of the hardest working members I have known, Dr. J. Wesley Rice, of Jackson, for Vice Speaker.

J. W. Bunting, M.D.: Mr. Speaker, I come from the boondocks, way up at the tip of the index finger of the mitt of Michigan. I represent my County Society, all of whose members believe that Louis Hayes has been doing a wonderful job for us as well as for the State Society.

Louis has been in that area for the past fourteen years. He has been President of his County Society for two years and Secretary for four years, and active on State committees for eight years.

We believe that Louis is a true student and disciple of the problems of us little guys from the boondocks. I therefore take great pleasure in nominating Louis Hayes for Vice Speaker of this House, from Alpena, Alcoa, Mount Morency and Presque Isle.

F. H. Power, M.D.: I too come from the northern part of the State, and would like to take this opportunity to say that our side of the State also recognizes the service that Louis Hayes has contributed to organized medicine in this House and to our part of the country in the matter of professional training and important postgraduate work as well.

I am very pleased to second the nomination of Dr. Hayes for Vice Speaker of this House.

F. C. Ryan, M.D.: Kalamazoo is very proud to place in nomination our own Dr. Don Marshall.

H. W. Harris, M.D. [Ingham]: I second the nomination of Dr. Don Marshall.

THE SPEAKER: Dr. Hayes and Dr. Marshall have been nominated along with Dr. Rice. Are there any other nominations?

L. F. HAYES, M.D.: Mr. Speaker, I would like to respectfully request that my name be withdrawn as a nominee for this office. If I may have one moment I would like to explain my reasons.

First, I think a run-off of three men does not give an active expression of the clear majority of this House, whereas, a run-off between two men gives very adequate expression of the majority opinion of the House.

Secondly, it is just beginning to filter through my brain the magnitude of the job I got this afternoon on the Blue Shield Board of Directors.

So, with the warmest personal thanks to those who have worked for me in this office and supported me, I would like to withdraw my name as a nominee. [*Applause*]

THE SPEAKER: Dr. Hayes' name will be withdrawn. Are there any further nominations?

DR. W. C. BEETS, M.D.: I move that nominations be closed.

[*The motion was duly seconded, was put to a vote, and was carried unanimously.*]

THE SPEAKER: Dr. Rice and Dr. Marshall are nominated for the office of Vice Speaker. We will use ballot No. 2.

L. A. DROLETT, M.D.: Mr. Speaker, I would like to move that this House of Delegates give a rising vote of thanks to Dr. Harold Falls for the dedicated job he has done as Vice Speaker of this House for the past two years.

[*The House arose and applauded.*]

THE VICE SPEAKER: That is thanks enough indeed. It has been a sincere pleasure to have served as your Vice Speaker and to assume the duties entailed in that office. I have many personal responsibilities that I cannot overlook in the coming two years, and for this reason I have had to withdraw. It has been one of the hardest decisions I have had to make, because this has been one of the most pleasurable experiences I have had in serving this excellent organization. [*Applause*]

[*Balloting*]

THE SPEAKER: Result of the election of alternate delegates to the American Medical Association: Dr. Martmer, Dr. Rice and Dr. Price, in that order. [*Applause*]

At the close of this meeting the new Councilors will be asked to come to the rostrum to pick up some material, such as badges, and so on, that go with the position of Councilor. All new Councilors will please come to the rostrum at the close of this meeting.

A. C. STANDER, M.D.: Once again this House of Delegates has been superbly informed and thereby able to intelligently and rapidly act upon the vast amount of business before it. This has been due to the excellent, rapid and efficient work of the headquarters staff in providing copies of resolutions, reports and other materials.

I move that this House of Delegates express its appreciation by a most deserved round of applause to the headquarters staff.

[*The House arose and applauded.*]

THE SPEAKER: Thank you, Dr. Stander.

XI—D. AMPAC

O. B. McGillicuddy, M.D., of Lansing, Chairman of the MSMS Council, urged all members of the House of Delegates to generously support the American Medical Political Action Committee.

J. W. RICE, M.D.: Gentleman, may I just say that I thank you for the confidence you have placed in me. I promise to do my best to serve you in the coming year. Thank you again. [*Applause*]

THE SPEAKER: Is there any further business to come before this House? If not, we stand adjourned.

[*The House adjourned sine die at 10:25 p.m.*]

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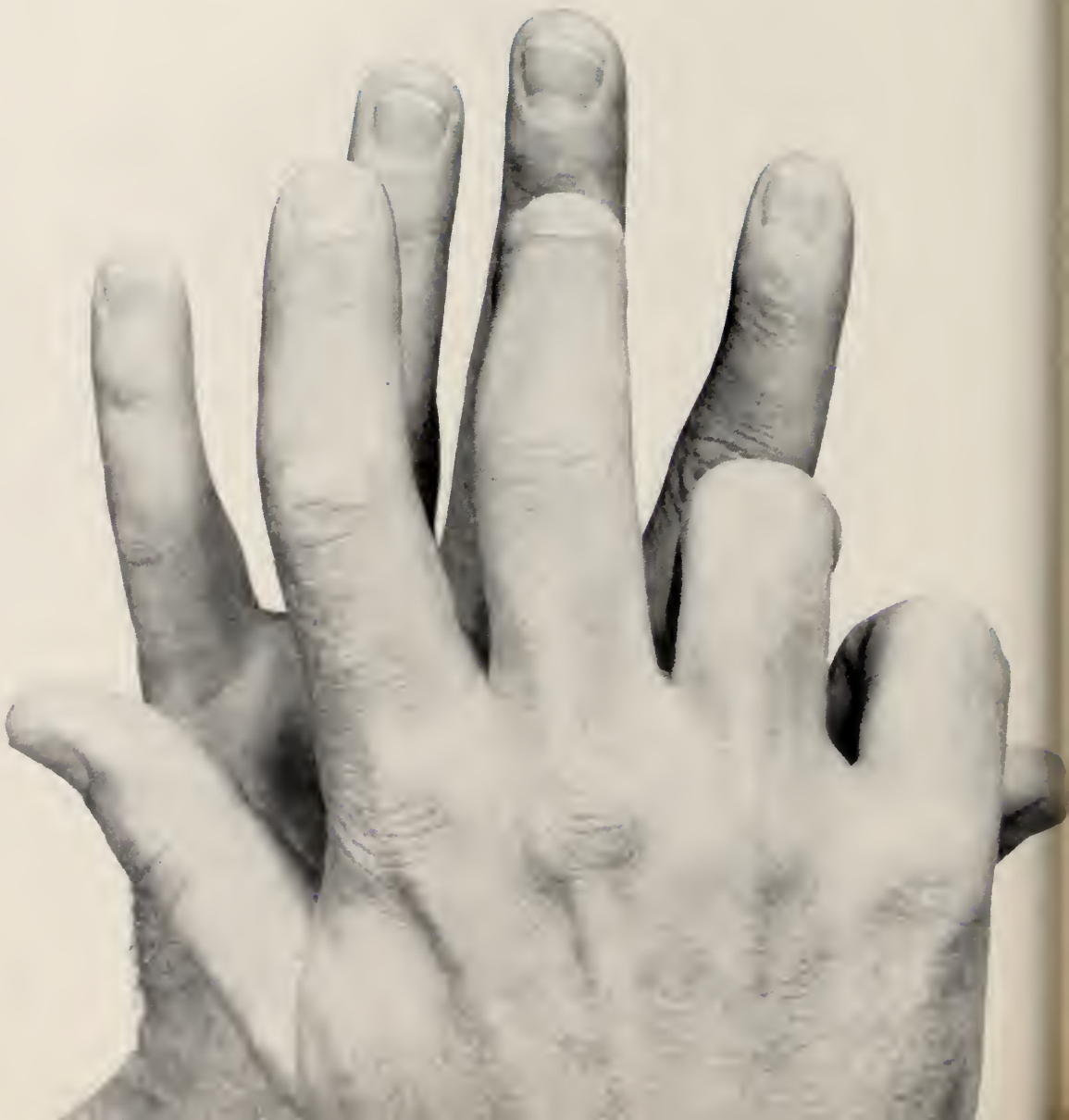
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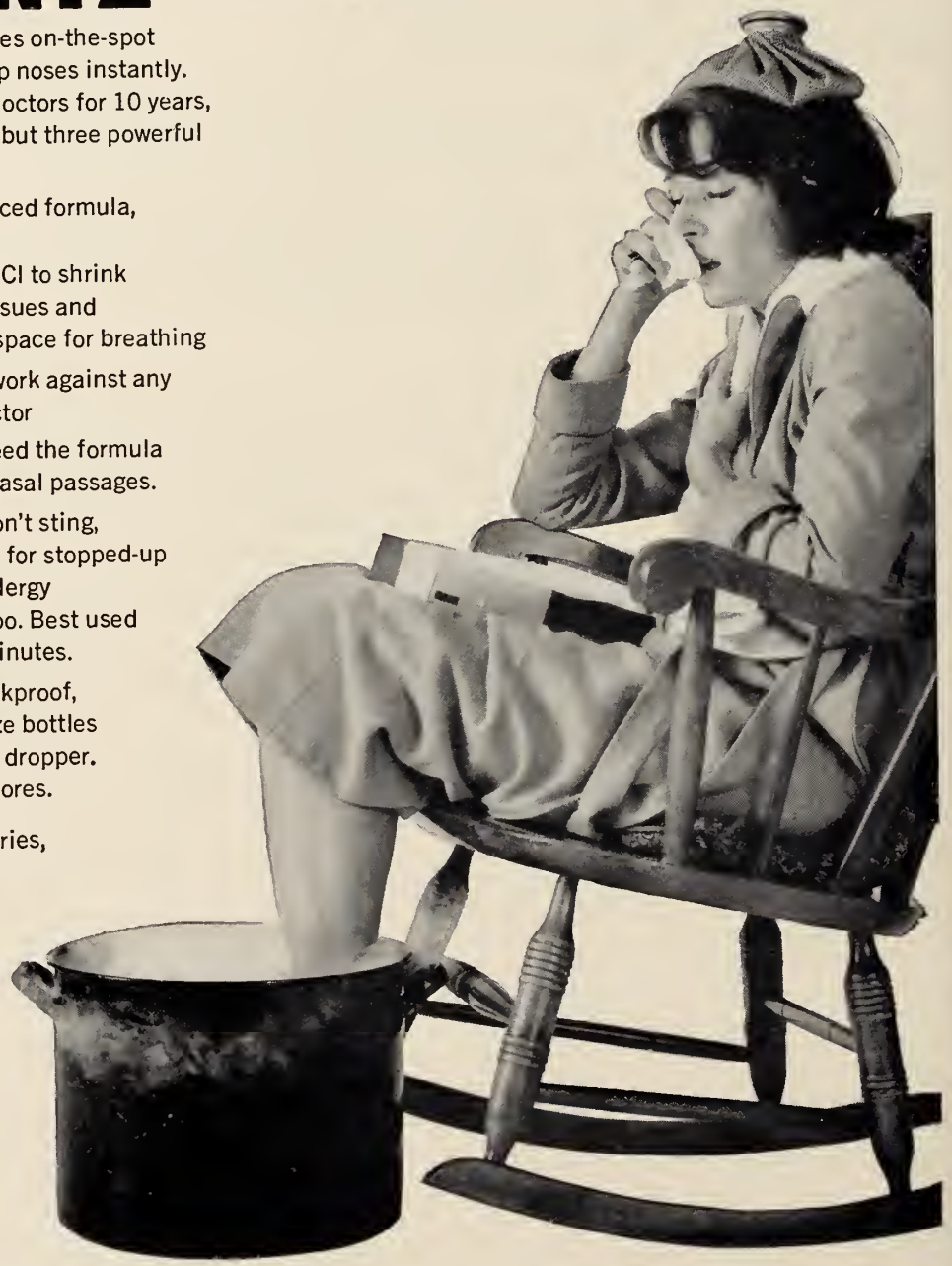
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Editor
WILFRID HAUGHEY, M.D.
610 Post Bldg., Battle Creek, Michigan

Executive Director and Business Manager of THE JOURNAL
WM. J. BURNS, LL.B.
120 W. Saginaw Street, (Box 152)
East Lansing, Michigan.

All communications relative to exchanges, books for review, manuscripts, should be addressed to Wilfrid Haughey, M.D., 610 Post Bldg., Battle Creek, Michigan.

All communications regarding advertising and subscriptions should be addressed to Wm. J. Burns, 120 W. Saginaw Street, East Lansing, Michigan. Telephone 337-1351 (Area Code 517).

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THE COVER

The scientific articles in this number are about Master Surgery; and the cover appropriately recognizes Frederick A. Coller, M.D., of Ann Arbor, a respected master surgeon. The portrait was painted by Prismatic Club member, Roy C. Gamble, and commissioned by the late Alexander W. Blain, M.D.

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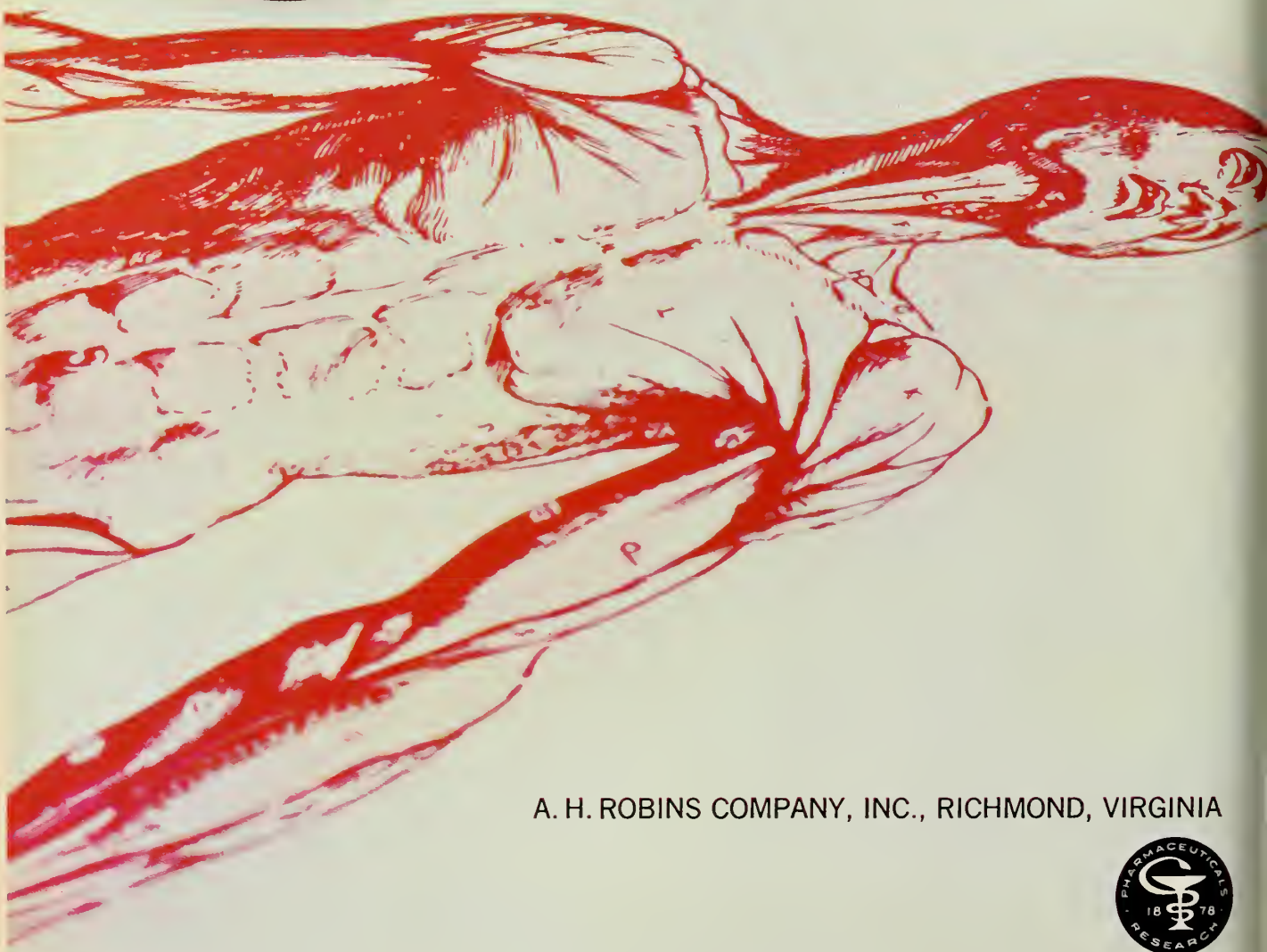
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One case of jaundice has been reported. Elevation of cephalin flocculation tests in several instances were not paralleled by changes in other liver function parameters. Urinalyses in 280 patients were essentially normal; false positive Benedict's tests, due to an unknown reducing substance in the urine, were reported in 9 patients.

contraindications: Do not administer to patients with known tendency to drug-induced anemia, or give to them only under careful supervision. Not recommended for use during pregnancy.

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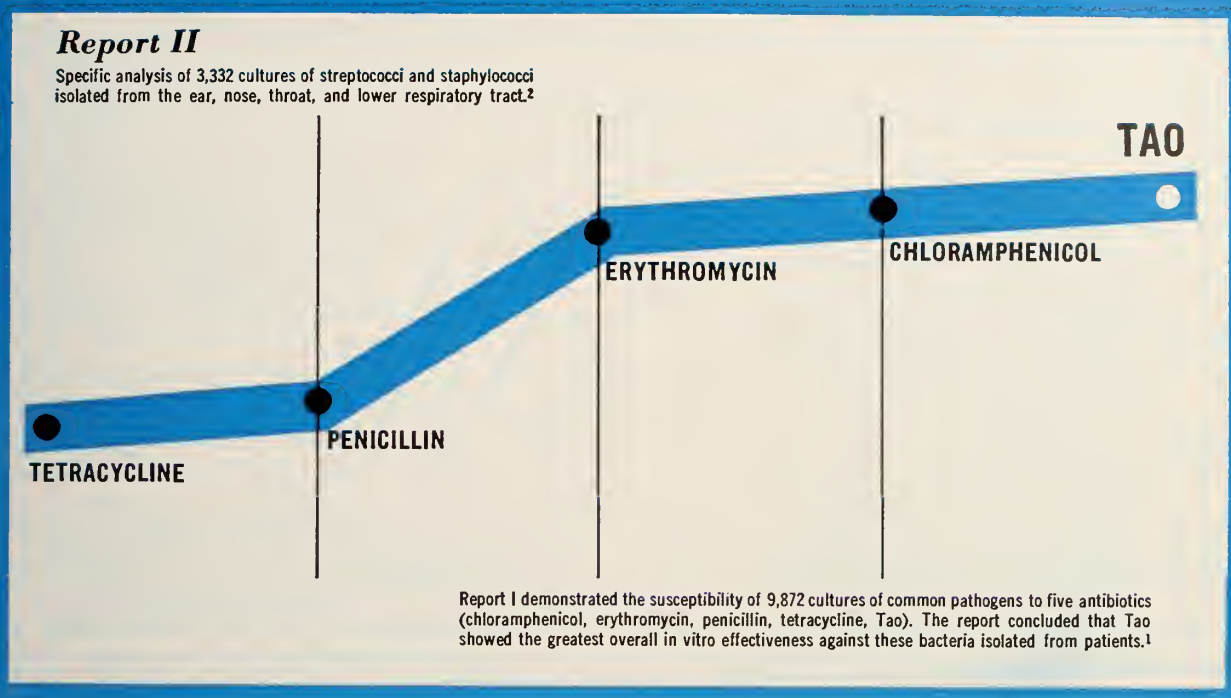
FROM A NATIONWIDE SURVEY OF 9,872 CULTURES OF COMMON PATHOGENS [1]

Conclusions of Nationwide Survey: *Report I*

1. Even after five years of general use, Tao, of the antibiotics tested, demonstrated greatest activity against respiratory streptococci and staphylococci (3,332 cultures).

2. Overall results showed a higher percentage of susceptibility among these common pathogens to Tao than to the other antibiotics. Susceptibility to Tao was greatest, not only in respiratory streptococci and staphylococci, but also in these organisms isolated from skin and soft tissue (3,423 cultures), genitourinary and gastrointestinal tracts and other sources (2,458 cultures). Susceptibility was equal to all antibiotics tested in pneumococci from unspecified sources (463 cultures), and less to Tao in H. influenzae from unspecified sources (196 cultures).

3. Tao has been used for five years without development of predictable cross resistance. In 1958 and 1961, approximately 73% and 70%, respectively, of erythromycin-resistant problem staphylococci showed susceptibility to Tao.[3,4] The present study confirms the continuing high degree of Tao activity even against these pathogens. Of 1,592 cultures of erythromycin-resistant staphylococci, 68% were susceptible to Tao, while in the reverse situation, only 33% of 768 Tao-resistant staphylococci were susceptible to erythromycin.



Report II

Results of Bacterial Susceptibility in 3,332 Respiratory Pathogens

References

1. "Bacterial Susceptibility Patterns: A Geographic Survey." Fowler, J. Ralph, M.D., and Watters, John L., M.D. Scientific Exhibit presented at the Annual Meeting of the American Society of Clinical Pathologists, Chicago, Ill., August 31 to September 9, 1962. 2. Fowler, J. Ralph, Watters, John L. and Levy, Arthur M.: Bacterial Susceptibility Patterns as Related to Geographic Variation and Anatomical Source. In press. 3. English, A. R., and Fink, F. C.: Antibiot. & Chemother. 8:420 (Aug.) 1958. 4. English, A. R., and Fink, F. C.: Antibiot. and Chemother. 11:648 (Oct.) 1961.

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President's Page

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Millions of words have been, and will be, said and written about governmental activity in the field of health and subject areas related to health.

Concurrent with this outpouring of opinion and information will be assorted exhortations to doctors of medicine to participate in the governmental machinery and the political forces related thereto in order that both the policy decisions made, and the methodology of policy implementation, be in the best interests of the people of our state and nation.

By our own intimate knowledge and experience in health work we are as a profession basically in accord on matters of principle involved, but I add my voice to those who call for the active participation of the medical profession in the carrying out of those principles in either government or voluntary action.

We are interested in the mental health picture in Michigan and recognize the need for many changes. Hospital licensing can be a burden rather than a boon if improperly devised.

We must see to it that patients, whether their care is governmentally subsidized or not, receive the same high quality of medical attention and that the systems formulated do not militate against this nor against any patients receiving care from the doctor of his choice. We can see no reason why the fees paid to doctors for their services should not be commensurate with the service rendered regardless of the governmental agency which authorizes the care.

Insofar as placing of responsibility is concerned, Michigan is fortunate that for the next two years the same party has preponderant strength in both the Executive and Legislative branches of state government. If that strength is used wisely great good can accrue to the citizens of our state. But, this should not cause us to feel that those who hold the political reins are all-knowing and omnipotent.

More than ever, it is necessary that doctors of medicine participate in government and in both political parties, either by serving on administrative boards and councils or standing for election.

In the latter regard, may I reiterate the obvious—it is vital that we think and act in regard to the spring election in April and we cannot too soon direct our efforts toward electing in 1964—and even in 1968—those people who will represent in the halls of Lansing and Washington the principles for which we stand.

MCI Clinical TV, Roundtables Planned



Two important features of the 1963 Michigan Clinical Institute, March 13-15, will be the one-hour daily Clinical Roundtables beginning at 8:00 a.m., and the daily two-hour clinical color television programs.

Program Committee Chairman Joseph L. Posch, M.D., Detroit, said the Roundtables will be small teaching classes with informal presentations and discussion of individual questions. MCI guests may sign up in advance for one or more of the nine sessions scheduled during the three days of the Institute. Classes will be limited to room capacity—approximately 30.

Closed circuit color television programs will be telecast from 10:30 a.m. to 12:30 p.m. daily from University Hospital, Ann Arbor. The programs have been arranged by a committee chaired by D. H. Kaump, M.D., Ann Arbor, through the cooperation of Smith, Kline and French Laboratories of Philadelphia.

Doctors will have a choice of three evening seminars to attend. Once again, a seminar open to the public will be presented each evening and another seminar, on Thursday, March 14, on "Suicide in General Practice and Psychiatry" will be offered only for doctors. The Wednesday March 13 public seminar will be about "Mental Retardation" and the Thursday March 14 public meeting will be on "Aging."

The overall MCI program is one of the best, with 86 speakers carefully selected to present educational material to aid the individual practitioner of medicine in his every-day practice.

MCI General Chairman George W. Slagle, M.D., Battle Creek, urges that members refer to the January Number of THE JOURNAL of MSMS for program information, including clinical roundtables, color televison subjects, the "main" Assembly presentations, and informative meetings of ancillary groups.

MSMS postgraduate credits are given to any member who attends the MCI.

You Are Invited To Attend 1963 MCI

We do hope that you will plan today to attend the 1963 MCI. It will provide clinical roundtables, lectures, closed-circuit color television, ancillary group meetings—and the chance to renew old acquaintances.

Join us in Detroit, on March 13-14-15, won't you?

Sincerely,

GEORGE W. SLAGLE, M.D., *Chairman*
Committee on Arrangements

MICHIGAN MEDICAL MEETINGS

Michigan Clinical Institute, March 13-14-15, Sheraton-Cadillac, Detroit.

Western Michigan Trauma meeting, April 17, Muskegon

Wayne University Medical Alumni Clinic Day, May 8, Sheraton-Cadillac, Detroit.

Michigan Health Council State Conference May 21-22-23, Pantlind Hotel, Grand Rapids.

MSMS Maternal and Perinatal Mortality Workshop, May 23-24, Gull Lake Conference Center, near Battle Creek.

MSMS Society Nights

Mecosta-Osceola-Lake County Medical Society held at Big Rapids, December 4, 1962.

North Central Medical Society held February 13, 1963 in Grayling.

Oakland County Medical Society at Birmingham, April 3, 1963.

Allegan County Medical Society, April 9, 1963.

Jackson County Medical Society, March 19, 1963.

Hillsdale County Medical Society (place and date not decided).

Old Fort Mackinac Hospital To Be Reopened by State

The Fort Mackinac Hospital, where William Beaumont nursed Alexis St. Martin back to health, is to be reopened this summer by the Mackinac Island State Park Commission.

Dr. Eugene T. Petersen, director of historical projects for the park commission, said planning and research for the hospital will start immediately.

Dr. Petersen said the hospital will be open to the public this summer.

"Our work may not be completed by then," he said, "but the public will be invited to see the inside of this very historical building."

"It will mark the first time since the withdrawal of soldiers from the fort in 1895 that doors of the hospital have been opened to the public," Dr. Petersen reported.

The restored hospital will contain an operating room and ward, both in an 1870-80 setting.

It was in the original hospital—starting in 1822 about four years after the facility was built—that Dr. William Beaumont conducted the first basic research on digestion.

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West Point, Pa.

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Chicago, Ill.
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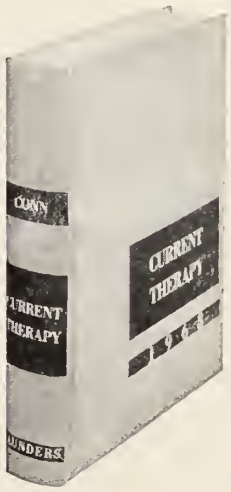
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Space No. 16
Julius Schmid, Inc.
New York, N. Y.

An interesting and informative exhibit featuring IMMOLIN Vaginal Cream-Jel for use without a diaphragm, RAMSES Flexible Cushioned and BENDEX Diaphragms; RAMSES Vaginal Jelly; VAGISEC Liquid and VAGISEC PLUS Jelly and Suppositories for vaginal trichomoniasis therapy; and XXXX (FOUREX) Skin Condoms, RAMSES, SHEIK and SHEIK LUBRICATED Rubber Condoms for the control of trichomonal reinfection.

(Continued on Page 136)

RELIEVE THE COLD SUPPRESS THE COUGH WITH NEW

'EMPRAZIL-C'

TABLETS

ANTITUSSIVE ▪ DECONGESTANT ▪ ANALGESIC

Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Acetophenetidin	150 mg.
Aspirin (Acetylsalicylic Acid)	200 mg.
Caffeine	30 mg.

*Warning—may be habit forming.

Complete literature available on request.

Also available without codeine as

'EMPRAZIL'®

TABLETS



BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.

1963 MCI Exhibitors

(Continued from Page 134)

Space No. 17
Sanborn Company
Waltham, Mass.

The new SANBORN/FROMMER CELL COUNTER as well as new ELECTROCARDIOGRAPHS of advanced design and function together with the latest models of other instruments for diagnostic use, will be displayed and demonstrated at the Sanborn Company Booth No. 17.

Demonstrations and/or data will also be available on Sanborn instruments for biophysical research—single and multichannel recording systems, monitoring oscilloscopes and physiological transducers.

Qualified Sanborn representatives will be pleased to answer questions and assist you with technical problems.

Space No. 18
Schering Corporation
Bloomfield, N. J.

A cordial invitation to visit the Schering technical exhibit is extended to all members. The products listed below will be featured: Chlor-Trimeton®, unsurpassed antihistamine; Celestone®, most active corticosteroid available; Trilafon®, the tranquilizer and antiemetic of unexcelled efficacy; and Naquival®, particularly effective in advancing or complicated hypertension.

Space No. 19
MSMS Life, Health and Accident Insurance Program
East Lansing, Mich.

You are cordially invited to stop at space No. 19 and discuss the MSMS Life, Health and Accident Insurance Program.

Representatives of the MSMS carriers will be present to answer questions concerning your MSMS group coverage.

Space No. 20
U. S. Vitamin & Pharmaceutical Corporation
New York, N. Y.

D B I—"broad-range" oral hypoglycemic agent. D B I, brand of phenformin (N^1-B-phenethylbiguanide HCl) is distinctly different in chemical structure and physiologic action from the oral hypoglycemic sulfonylureas. It effectively lowers blood sugar and eliminates glycosuria in mild, moderate and severe diabetes. D B I, in combination with insulin, improves regulation of "brittle" adult and juvenile diabetes. In juvenile diabetes, D B I often permits up to 50% reduction in insulin requirement. Also effective in the insulin-resistant, and in primary and secondary tolbutamide and chlorpropamide failures. Full details available.

Space No. 21
Sandoz Pharmaceuticals
Hanover, N. J.

Sandoz Pharmaceuticals cordially invites you to visit our display at Booth No. 21, where we are featuring Mellaril, Cafergot PB, Sansert and Fiorinal.

Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

Space No. 22
Milex Products
Oak Park, Mich.

Milex Company is again pleased to exhibit a complete line of gynecic specialties: Trimo-San, for poly-vaginal disorders; Amino-Cerv, for cervicitis and senile vaginitis; Counselling Books (marital, menopause and teen-age); Milex Folding Pessaries, also Inflato and Cube Pessaries and items for infertility. We also have a new Utero-Tubal Cannula for tubal insufflation.

Space No. 23
Merck Sharp & Dohme
West Point, Pa.

Space No. 24
Wm. S. Merrell Company
Cincinnati, Ohio

Space No. 25
Fuller Pharmaceutical Company
Minneapolis, Minn.

TUCKS—A unique substitute for toilet tissue in the treatment of pruritus ani and other anorectal conditions—also its new witch hazel analogue, TRIAMEL OINTMENT and CREAM. THERAPADS, a new approach to daytime care in acne vulgaris. Samples for personal use and clinical trial will be gladly arranged for by our representatives in attendance.

Space No. 26
Smith, Kline & French Laboratories
Philadelphia, Pa.

Space No. 27
Desitin Chemical Company
Providence, R. I.

Desitin Ointment: For treatment of burns, ulcers, diaper rash, et cetera.

Desitin Powder: Relieves chafing, sunburn, diaper rash, et cetera.

Desitin Suppositories and Rectal Ointment: Relieve pain and itching in hemorrhoids, fissures. No anesthetics.

Desitin Acne Cream: Flesh-tinted "Medicream" for the treatment of Acne.

Desitin Cosmetics and Nursery Soap: Supermild.

Desitin Suppositorriea with Hydrocortisone: Prompt relief in inflammatory conditions, proctitis, severe pruritus, edema. No anesthetics.

Desitin Ointment with Hydrocortisone: Anti-inflammatory, anti-pruritic, anti-allergic.

Cor-D-Tar Cream: Water washable, stainless cream for eczematous, pruritic dermatoses.

New—ANAFUNG: antifungal powder, cream, aerosol spray.

Space No. 28
Lederle Laboratories
Pearl River, N. Y.

Members of the Michigan Clinical Institute and their guests will be most cordially welcomed at the Lederle booth, which is No. 28. Our medical representatives, who have

(Continued on Page 138)



GAS air conditioning in this new medical clinic? Of course!

And it's one of the most modern, most welcome features offered by this Dearborn Township medical/dental building.

Matter of fact, the trend to Gas air conditioning continues to grow every day. The reason is simple—and logical. Year 'round Gas air conditioning confers benefits not available with any other method.

Here are just *some* of the benefits of Gas air conditioning. Average fuel savings of from 17% to 31% while providing complete 12-month comfort—summer cooling and dehumidification, winter heating and moisturizing. Free 24-hour service. Free spring and fall system checkups.

Thinking about building? Then think in terms of Gas air conditioning. It makes the most sense—from *every* angle. Call Michigan Consolidated Gas Company, and ask one of our Air Conditioning Specialists for the whole story. He has good news for you.

MICHIGAN CONSOLIDATED GAS COMPANY

1963 MCI Exhibitors

(Continued from Page 136)

access to the world-wide Lederle research organization, are prepared to furnish information regarding Lederle products, particularly Varidase Oral and other products relating to subjects of your assemblies and clinical roundtables.

Space No. 29
C. A. Fisher & Sons
"Zimmer" Distributor
Toledo, Ohio

C. A. Fisher & Sons, your ZIMMER FRACTURE EQUIPMENT distributor, cordially invite you to visit their display. The latest in Fracture and Orthopedic equipment will be on exhibit. Featured will be the Snyder Hemovac for closed wound suction drainage.

Space No. 30
A. Kuhlman & Company
Detroit, Mich.

The A. Kuhlman & Company cordially invites you to visit space No. 30 and discuss with us our complete line of examining room furniture, diagnostic instruments, surgical instruments and physical therapy equipment.

Space No. 31
Ross Laboratories, Inc.
Columbus, Ohio

Ross Laboratories, manufacturer of Similac, features SIMILAC WITH IRON, supplying 12 mg. of ferrous iron per quart of feeding at no additional cost. SIMILAC WITH IRON is designed for use with the premature from birth, and to provide prophylaxis against iron depletion starting about the fourth month or 14 pounds. Information about SIMILAC PM 60/40 and the newest Ross Booklets will be available.

Space No. 32
Medical Protective Company
Fort Wayne, Ind.

As the No. 1 Malpractice Insurer, The Medical Protective Company offers unexcelled coverage. With exceptional proficiency in defense, so essential to the Doctor's protection today, its experience in successfully handling 84,000 claims and suits during sixty-four years of Professional Protection Exclusively is unparalleled in the professional liability field.

Space No. 33
Ciba Pharmaceutical Products
Summit, N. J.

Space No. 34
Fellows-Testagar
Detroit, Mich.

Space No. 36
Gray Mfg. Company
Hartford, Conn.

Space No. 37
Michigan Medical Service
Detroit, Mich.

Space No. 38
Rupp & Bowman Company
Highland Park, Mich.

Welcome, members and guests. See the latest Push-Button ECG Machine and other interesting items.

Space No. 39
Detroit X-Ray Sales Company
Detroit, Mich.

Space No. 40-41
Parke, Davis & Company
Detroit, Mich.

Medical service members of our staff will be in attendance at our booth to discuss important Parke-Davis specialties which will be on display.

Space No. 42
The Upjohn Company
Kalamazoo, Mich.

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are her to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

Space No. 43
Abbott Laboratories
North Chicago, Ill.

Abbott Laboratories invites you to visit our exhibit. Our representatives will be happy to answer any questions you may have concerning our leading products and new developments.

Space No. 44
S. J. Tutag & Company
Detroit, Mich.

Space No. 45
Pet Milk Company
St. Louis, Mo.

Our representatives will appreciate the opportunity of discussing with you SEGO Liquid Diet Food and the unique "Four Phase SEGO Diet Plan." In addition, we are featuring the "Pet Diet File" providing information on ten special diets. Patient education and prescription material on Pet Evaporated Milk for infant feeding is available also.

Space No. 46
Wyatt Surgical Supply Corporation
Adrian, Mich.

Space No. 47
Pacific Medical Equipment Co.
North Hollywood, Calif.

Audio-Digest Foundation (a non-profit subsidiary of the California Medical Association), gives the busy physician a time-saving tour through the best of some 600 current medical journals, plus the highlights of scores of national meetings. Time-proven, but still unique—these medical tape-recorded services are now offered in six series—General Practice (issued weekly and bi-weekly), and Pediatrics, Internal

(Continued on Page 140)

For your elderly arthritic patients



AN EFFECTIVE GERIATRIC ANTIARTHRITIC WITH DISTINCTIVE SAFETY FACTORS

safely indicated – even when **OSTEOPOROSIS** is present

PABALATE-SF, which has been found "superior to aspirin in the treatment of chronic rheumatic disorders,"[1] possesses distinctive **Safety Factors** for elderly arthritics, even when osteoporosis is present: (1) its potassium salts cannot contribute to sodium retention; (2) its enteric coating assures gastric tolerance; and (3) it does not produce the serious reactions often noted during therapy with steroids or pyrazolone derivatives.

In each persian-rose enteric-coated tablet: potassium salicylate, 0.3 Gm.; potassium para-aminobenzoate, 0.3 Gm.; ascorbic acid, 50 mg.

1. Ford, R. A., and Blanchard, K. P.: J.-Lancet 78:185, 1958.

Precaution: Occasionally, mild salicylism may occur, but this responds readily to dosage adjustment. In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Supply: Bottles of 100 and 500 enteric-coated tablets.

Pabalate®-SF

Robins

(the new, convenient way to prescribe Pabalate-Sodium Free)

A. H. ROBINS COMPANY, INC., RICHMOND, VIRGINIA

1963 MCI Exhibitors

(Continued from Page 138)

Medicine, Surgery, Obstetrics and Gynecology, Anesthesiology (all issued semi-monthly). Digest subscribers listen in their car, home or office. Carefully selected tap equipment for playing the Digests is offered at the convention by Pacific Medical Equipment Company.

Space No. 48
Johnson & Johnson
New Brunswick, N. J.

Johnson & Johnson will display the latest improvements in surgical dressings, as developed by the Johnson & Johnson Research Laboratories. Of special interest is SURGICEL Absorbable Hemostat, a major advance in the control of hemorrhage which does not depend upon the normal clotting mechanism. DERMICEL Surgical Tape, a newly-improved high strength special-purpose dressing tape for patients with unusual adhesive tape sensitivity, is an outstanding addition to the complete line of adhesive tape products. Other products, designed for your office, hospital or patient use, are also displayed. You will find well-informed representatives pleased to discuss these products or provide information on any other items made available by the world's largest manufacturer of surgical dressings and baby products.

Space No. 49
Cunningham Drug Stores, Inc.
Detroit, Mich.

Space No. 50
Cameron-Miller Surgical Instruments Co.
Chicago, Ill.

Space No. 51
C. J. Rouser Supply Company
Lansing, Mich.

Technicians will be available at our booth to discuss new developments in Pulmonary Therapy Equipment, as well as various testing devices which we install in the Doctor's Office, the Hospital, and in the Patient's home at the request of the Physician. See and discuss Bird Respirators and controls, therapy and emergency equipment, Jones Pulmonors for testing, Mistogen, Air Shields, DeVilbis and many others.

Space No. 52
Ayerst Laboratories
New York, N. Y.

Ayerst Laboratories extends an invitation to visit our exhibit located in Booth No. 52 where our representatives will be pleased to discuss Ayerst products with you.

Space No. 53
The Stuart Company
Pasadena, Calif.

A cordial invitation is extended to all members and guests attending this meeting to visit the Stuart Company booth. Specially trained representatives will be in attendance to answer your questions on new products, developed in our modern laboratories, which have particular interest for the medical profession. Products featured are Mylanta, Stuart Prenatal, Mulvidren and Mulvidren-F.

Space No. 54
Michigan Association of Collection Agencies
Battle Creek, Mich.

Space No. 59
Detroit Stepulator Sales, Inc.
Grosse Pte. Woods, Mich.

Space No. 60
A. S. Aloe Company
St. Louis, Mo.

Space No. 61
Eli Lilly & Company
Indianapolis, Ind.

You are cordially invited to visit the Lilly exhibit located in space 61. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

Space No. 62
Continental Medical Electronics
Hinsdale, Ill.

Space Nos. 63-64
Coca-Cola Company
Atlanta, Ga.

Ice-cold Coca-Cola served through the courtesy and cooperation of the Detroit Coca-Cola Bottling Company, and The Coca-Cola Company.

Space Nos. 65-66
G. A. Ingram Company
Detroit, Mich.

Space No. 67
Maico Hearing Service
Detroit, Mich.

Space No. 68
J. B. Lippincott Company
Philadelphia, Pa.

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching are a continuation of more than 170 years of traditionally significant publishing.

Space No. 69
G. D. Searle & Company
Chicago, Ill.

Space No. 70
Mead Johnson Laboratories
Evansville, Ind.

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.



Put your low-back patient back on the payroll

Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, *fast!*

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

This was demonstrated by Kestler in a controlled study: average time for full recovery was 11.5 days with Soma, 41 days without Soma. (J.A.M.A. **172**:2039, April 30, 1960.)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets.
USUAL DOSAGE: 1 **TABLET Q.I.D.**

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey

EAR ACHROMYCIN®

Tetracycline Lederle

ACHROMYCIN Ear Solution concentrates the potent activity of tetracycline for effective local anti-infective action. It is especially useful in otitis externa due to mixed organisms. Patient antibiotic intolerance and tissue toxicity are minimal. ACHROMYCIN Ear Solution is effective against both Gram-positive cocci and Gram-negative bacteria.

ACHROMYCIN Ear Solution: Each unit contains 1 bottle Powder, 50 mg.: 1 bottle Diluent (benzocaine 5% solution in propylene glycol)

When oral therapy is indicated

ACHROMYCIN® V

Tetracycline HCl with Citric Acid Lederle
Capsules—250 mg., 100 mg.



Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y. Lederle

EVERYBODY DOES IT





Toot! We have a nice little bargain, too...

Accustomed as we are to talking about purity, potency, stability, things like that, we thought you might like to know that mothers can make a nice saving on Vi-Daylin Chewables for the next few weeks. Nothing complicated. She buys a bottle of 100 at the regular price. She gets a bottle of 30 free. Big deal? Well, not a bad one. It means she's getting her Vi-Daylin for less than 3¢ per daily dose per child. You might find some vitamins somewhere that would cost even less. But will the youngsters take them?

Vi-Daylin—Vitamins A, D, B_1, B_2, B_6, B_{12}, C, and Nicotinamide, Abbott

ABBOTT 75TH ANNIVERSARY



301079

These Chewables Taste as Good as They Look

(AND THEY'RE SUGAR-FREE, THANKS TO SUCARYL®)

First cousin to an orange. Next door neighbor to a lemon – that's new VI-DAYLIN® CHEWABLE with *Entrapped* Flavor.

They look like footballs and smell like candy and you've never tasted a chewable vitamin quite like them. What surprises you is not so much what you taste as what you *don't* taste. Vitamins. They simply don't come through – either in taste or aftertaste. Even the riboflavin is trapped and civilized.

Our dual coating process does it – seals the raw vitamin tastes, protects the delicate flavoring agents. Releases the sweet citrus flavor in the mouth, the vitamins in the g-i tract. With *both* vitamins and flavors entrapped, there's just no chance of the tablets turning musty in the bottle.

Rational formula. And sweetened with sugar-free SUCARYL.

If they look good to you, imagine what youngsters will think.

75TH ANNIVERSARY ABBOTT



SUCARYL–Abbott's Non-Caloric Sweetener.
VI-DAYLIN–Vitamins A, D, B_1, B_2, B_6, B_{12}, C, and Nicotinamide. Abbott.

Bay County Cooperates In Diabetes Testing

About 5,000 residents in Bay County voluntarily took diabetes tests in a community project sponsored by the Bay County Medical Society, Bay County Pharmaceutical Association and the Bay City Junior Chamber of Commerce.

Residents were able to go to the pharmacies in the county for the Dreypak test. The Bay City Clinical Laboratories conducted the tests.

C. E. Reddick, M.D., coordinated this community health project.



Praises Town Meetings

The experience that several Michigan component medical societies had last year in presenting town-hall meetings with other groups is described in the current issue of the American Medical Association publication, "The PR Doctor." The AMA publication points out that "In Michigan, doctors, businessmen and agricultural spokesmen have united forces and worked out a positive program to broaden public knowledge of major legislative issues facing the country today."

Wayne Doctors Serve Youngsters

Wayne County physicians, with the aid of volunteer workers, are currently giving free physical examinations to 700 East Detroit children selected by their teachers as those most in need of attention. Many have never seen a doctor. The word "Pediatrician" is unknown to them. They live in homes where money is for food, and illness is a luxury they can't afford.

Each Tuesday, about 6:00 p.m., Internists E. Osborne Coates, M.D., Richman Smith, M.D., and George C. Bower, M.D., along with Pediatrician Gordon Manson, M.D., leave Ford Hospital and rush to Franklin Settlement, to examine an average of 40 children. The hour is late when they finish, but they remain to discuss important cases, and make decisions about referrals. In one of every 10 children, they have found what Dr. Coates calls "a critical abnormality."

Nurses, teachers, social workers, parents, and students are giving their time and energy by helping with the paper work, preparing the children for examination, laboratory tests, babysitting, transportation, and solving many other problems that arise with a venture such as this.

This is only the beginning. Recently, each of the 1,400 children at Bunche School had a vision test. Other programs planned include tuberculin tests, and a 6-week nutritional course for mothers.

The City of Detroit, through Dr. C. Dale Barrett, Director of Child and School Health, is broadening this program, which is backed



Photomotograph

A five-minute test with the Burdick Photomotograph indicates the patient whose record is shown above is hypothyroid. The entire procedure for this reliable diagnostic test for thyroid dysfunction — *positioning the patient, connecting the photomotograph to the electrocardiograph, tapping the Achilles tendon, checking the results* — takes but a few minutes, and the record is available for immediate diagnosis and permanent filing.

This simple yet reliable test should be as much a part of the complete physical as an ECG. Write us for full information.

Kupperman et al have reported the photomotogram test is unaffected by most of the conditions which invalidate other diagnostic procedures as a measure of thyroid dysfunction. Ask us for a complete reprint of this authoritative article—without cost or obligation.

THE G. A. INGRAM COMPANY

4444 Woodward Avenue
Detroit 1, Michigan
Telephone TEmple 1-6880

by the Wayne County Medical Society, Board of Education and City Health Department.

Several doctors in the area have agreed to see children referred to them after their physical examinations at Franklin Settlement. Developing a family relationship with a neighborhood doctor is one of the important goals set by this group.

Discuss Disaster Medical Care

"Survival in the Sixties" was the theme of the 13th County Medical Societies' Conference on Disaster Medical Care in Chicago, November 3-4. Subjects which were explored included "The American Community Looks at Civil Defense," "Natural Disasters and Community Hospitals: Are they prepared?" and "National Self-Help Program and Austere Medical Care."

Max L. Lichter, M.D., Melvindale, is chairman of the AMA Committee on Disaster Medical Care, responsible for this AMA conference.

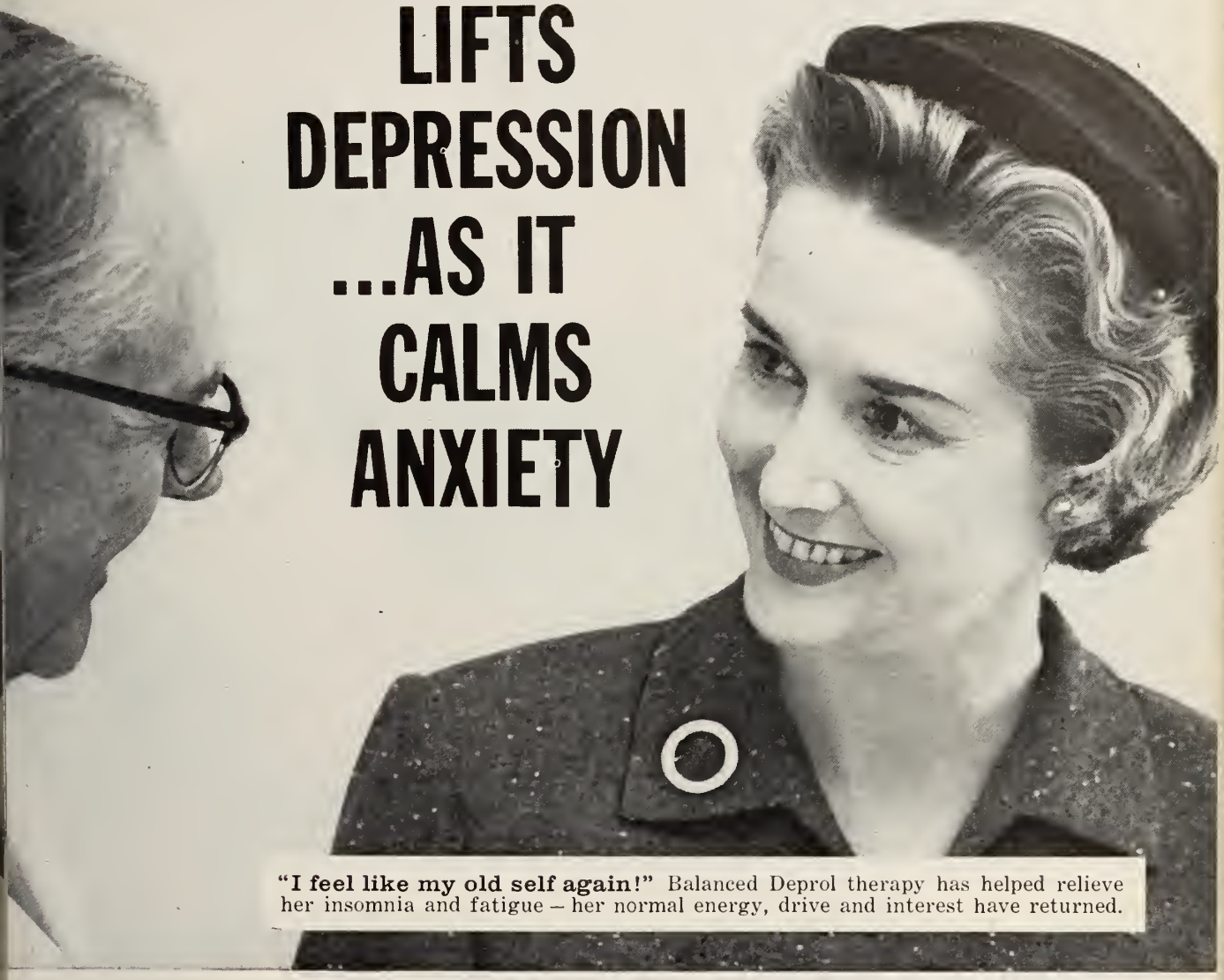
Urges Induction Rites

In a special booklet for county medical societies giving suggestions on getting new members into active society participation, the New York State Medical Society says: "In view of the milestone election to membership in a county medical society represents in the life of a young physician, it is only fitting that it take place amid appropriate ceremonies. Many of our most active county medical society leaders date their interest in medical affairs to events surrounding their acceptance in their county society. Others who seldon attend their county society meetings indicate that their lack of interest, and therefore, their infrequent attendance at society meetings is due to the casual manner in which they were elected to membership in their county society."

Membership Brochures Popular

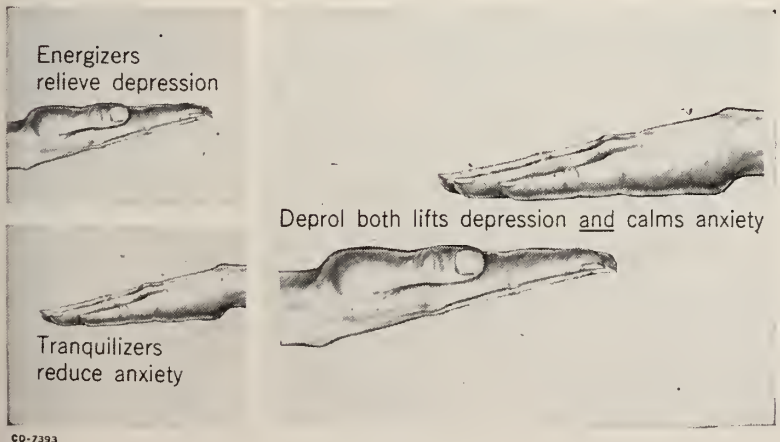
Many county societies have prepared leaflets or brochures pointing out the advantages of society membership. These leaflets range from very simple four-page pieces to elaborate printed brochures. A typical leaflet gives the following information: what the . . . medical society is, how it operates, its officers, its finances, its dues, and its activities. Others include a little society history, list the society's objectives, outline its services to members, both scientific and non-scientific, and also give the obligations of members. Also of value in impressing upon applicants the values of organized medicine are handbooks which serve as the physician's guide to membership services.

LIFTS DEPRESSION ...AS IT CALMS ANXIETY



"I feel like my old self again!" Balanced Deprol therapy has helped relieve her insomnia and fatigue – her normal energy, drive and interest have returned.

Brightens mood...relaxes tension



CD-7393

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be increased gradually up to 3 tablets q.i.d. With establishment of relief, the dose may be reduced gradually to maintenance levels.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scored tablets.

Write for literature and samples.

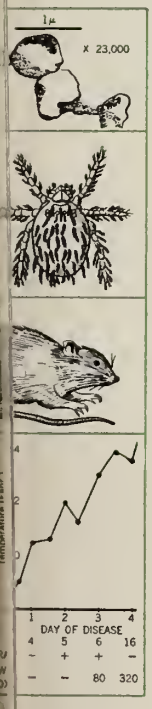
Deprol®

WALLACE LABORATORIES
Cranbury, N. J.



rom tsutsugamushi in Malaya to otitis media in Michigan

ere is a world of experience behind BRAND OF OXYTETRACYCLINE **Terramycin®**



Whether treating tsutsugamushi or a host of other infections, physicians throughout the world continue to rely on TERRAMYCIN for its outstanding safety, effectiveness and excellent tolerability. Not a single case of phototoxic reaction, blood dyscrasia or neurologic disturbance directly attributable to TERRAMYCIN has been reported in more than 3,000 clinical papers in the last 12 years. *In your practice, the next infection you see will very likely be "Terra-responsive."*

Tsutsugamushi, or scrub typhus, was responsible for incapacitating nearly 7,000 American soldiers during World War II. This disease is prevalent in areas overrun by jungle rats infested with mites carrying *Rickettsia tsutsugamushi.* Symptoms include a primary lesion at the site of the mite-bite, fever reaching as high as 105°, and a cutaneous rash. Injected conjunctivae, deafness, delirium and racking cough mark the advance of the disease. Mortality rates as high as 60 per cent have been reported. Terramycin is one of the antibiotics of choice for rapid and effective control of the acute stage of the infection. Patients become afebrile and virtually asymptomatic 24 to 36 hours after beginning treatment.

IN BRIEF The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. For complete information on Terramycin dosage, administration, and precautions, consult package insert before using. *More detailed professional information available on request.*

Science for the world's well-being®

Pfizer

PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc.
New York 17, New York



mudrane®

the bronchodilator
with the intermediate dose of KI

A combination of the four most widely used drugs for the treatment of asthma. Each Mudrane tablet contains Potassium Iodide 3 grains, Aminophylline 2 grains, Ephedrine HCl ¼ grain, Phenobarbital ⅓ grain . . . compounded for prompt absorption and balanced action, and buffered for tolerance.

Dispensed in bottles of 100 and 1000 tablets

WM. P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA

Manufacturers of ethical pharmaceuticals since 1856

AMA President Urges Doctors "To Tell the True Story"

(Excerpts of address by George M. Fister, M.D., President, AMA, at AMA House of Delegates meeting, Los Angeles)

PUBLIC RELATIONS 151



Hippocrates, the great Greek physician, once said, "Strong maladies require strong medicine." These words have special meaning for the medical profession today.

One malady plaguing medicine is the slurs being voiced about our nation's unique system of medical care by those who have something else in mind for the people of America.

Some of the slurs, born of misunderstanding, can be forgiven. Others appear to have been deliberately conceived to discredit our medical care system and our profession.

Many of the disparaging remarks are half-truths being disseminated in the apparent hope that if repeated often enough they will insidiously eat away at free enterprise medicine as we know it today.

The symptoms are distressing in their potential impact on the welfare of the nation.

The strong medicine needed to arrest this malady is to tell the people the truth about United States medicine . . . its past accomplishments, the breakthroughs just over the horizon, and the great vistas opening up to medical science.

The medical profession must play a major role in treating this malady. You and I must set the record straight—and keep it straight—by telling the true story of medicine as it is practiced in this country, and by telling what the few who are slurring our system are touting as a substitute.

In brief, we must diagnose the malady and treat it with truth.

Our medical care system never has been, nor should it ever be, exempt from constructive criticism. No one has claimed, nor should he claim, that it is perfect. While our system has known no peer in history, all of us are continuously working to make it better.

What about those who want to change our system? Are they advocating something better or something to correct the shortcomings of our present system? No. Strangely enough, they want to trade our present medical care system for bits and pieces of other systems that are alien to our traditions and history.

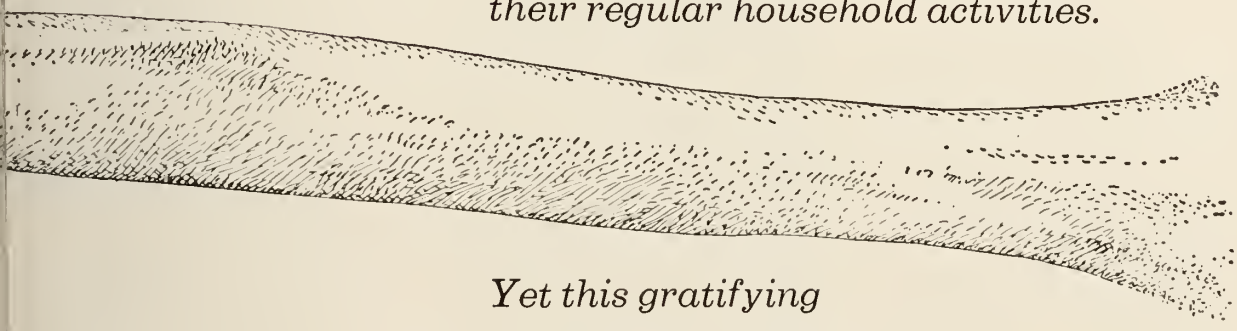
The great edifice of American medicine has been built upon strong pillars. It has stood the test of time and it has kept pace with changing conditions. We must not let it be disfigured by the few who are chipping away at its foundations.

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The "Split Personality" Of the American Economic Conservative

(By Dr. C. T. HARDWICK, University of Detroit,
Michigan State Medical Society Economic Consultant)



Today's conservative has developed a "split personality." He voices preference for independence, individual initiative, freedom of choice, personal responsibility, limited government action and the like. At the same time, the conservative is overwhelmed with the economic wants of the poor in an affluent society, the so-called "unmet" health needs of some, the high cost of war, and the challenges of housing and education for the exploding population. Since all of these are beyond individual solution, the conservative is seduced with the proposed solutions by central government.

Thus, we see that the conservative feels strongly about his traditional beliefs but these fade away under the propaganda circulated in popular magazine and newspaper articles prepared by those believing in collective action.

The "split personality" of today's conservative arises from a conflict between his theory about the advantages and usefulness of the free marketplace and the inadequacies of the results which he is told only government can overcome in a concerted action.

This presentation aims to be clinical about the reasons for the split between the conservative's *principles* and his *practices*. It does not intend to provide answers because coming to a conclusion after examination of the facts is an individual responsibility in a free society for conservatives as well as all other citizens.

About two hundred years ago, a political philosopher, Jeremy Bentham, presented arguments to separate economics from politics, which led up to independent writings and theories down to our times.

Although most people still give lip service to the separation of economics and politics, they too often subscribe to programs of integration of economic action, especially by the federal government. This is particulary true in troublesome economic cases where they assume the only answer is to ask Washington to do it. Remember every time government steps in to dominate a segment of the economy, we lose some degree of freedom. Freedom is assured only when we continue to separate economic free choice from political control and domination.

In other words, government action seeking social welfare goals for some infringes upon the freedom of all. As the saying goes, we cannot have our cake and eat it simultaneously. That means the free citizen does not ask what can I get from government but resolutely he decides to go it alone or do it voluntarily with others. Only in desperation will free men ask government to do collectively that which they can ordinarily and should be doing themselves. This is the essence of protecting their freedom from encroachment by government. In the interest of preserving freedom, the conserva-

tive has two guiding, American, constitutional principles to keep in mind, namely:

1. Scope of federal government activities MUST be limited to the specific assignments of the Constitution.

2. Government power MUST be dispensed from Washington to the states and local units.

The foregoing are paramount to all other considerations. Concentration of economic power in the hands of the federal government invites someone to do harm as well as good. Reliance and dependence on the state for economic progress is contrary to American historical experience. In the economic world there are two ways of allocating economic resources and coordinating economic activities, namely:

1. Central direction and unitary control by national government or determination via the ballot box, i.e., socialism.

2. Voluntary action of individuals and groups in the free market place, i.e., American competitive enterprise.

Experience has demonstrated the advantages of the free, voluntary system over the authoritarian dictates of a central government. The American free system permits individual choice according to personal preference, whereas a state system replaces freedom in favor of central choice of what they think others want thus "they" know better than "we" in allocating economic resources.

In the authoritarian system of central direction, conformity rules instead of singular choice. Of course free choice may not be perfect or in accord with central values. Sometimes, in a free society, individuals spend for amusement or drinks in preference to education or health but who is to say what is best for them. The central direction assumes some few have high values superior to the masses but we traditionally believe in freedom to choose according to individual values assisted by education but not replaced by the chosen few!

Furthermore, the making of economic choice in the political arena often means conformity enforced by the majority which will disrupt social harmony as well as replace the worthy goal of individual freedom. Sometimes, and even more often than not, economic welfare cannot be achieved without political warfare and free individuals should not be sacrificed for group conformity unless a real emergency exists.

Consequently, we face two threats to our American way of life. Externally, the revolutionary communists promise to bury us with collective forces. In addition, the internal group of men with good intentions are trying to reform our individualistic society with abandonment of personal freedoms in favor of a domestic collective system. At present, the latter group are the particular concern of the economic conservative. Of course, we want to mobilize our forces to fight communism but at the same time we do not want to destroy our values that distinguish us as Americans.

One way to defend ourselves from internal revolution is to review and re-establish our fundamental beliefs, goals and principles of the American way of life against which we carefully check all proposals for change. This means we must reaffirm our fundamental guidelines in the political, socio-economic and professional areas of thought before subscribing to proposed "goody" practices.

The purpose of this analysis is not to decide questions for the community but rather to clear up our thinking about issues involving the choice between individuals and central government.

We are not against the solving of social problems or achieving welfare ends but we are deeply concerned with the practical means which if always in favor of central government will in itself destroy individual freedoms and voluntary ways of living. We prefer that government assures the climate to permit individuals to help themselves through private efforts and free market choice.

Men of good will know and fully realize that the dynamic changes in the twentieth century cannot be solved with eighteenth century answers. Economic conservatives are for progress based upon wisdom and evolutionary changes in keeping with our heritage of individual freedom and responsibility. These eternal values we will fight for and struggle against internal as well as external enemies and anything less would be unbecoming to real Americans.

Medical Maxims

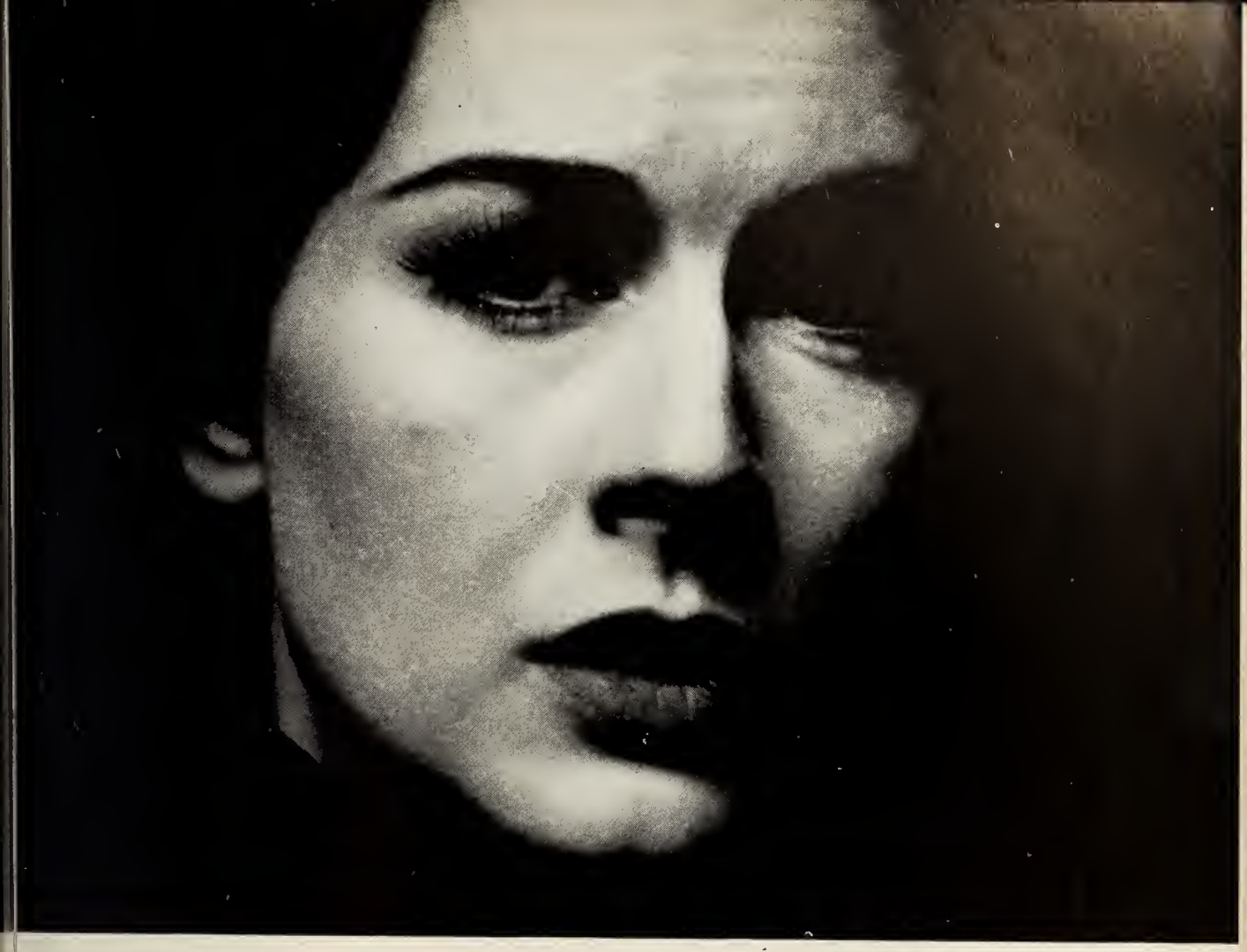
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Anterior Cervical Fusion

Its Development and Current Role

Robert W. Bailey, M.D.
Ann Arbor, Michigan

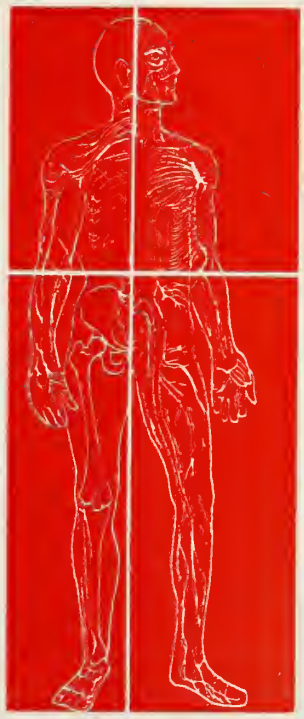
SINCE 1952, anterior cervical spinal fusion has found increased applicability at the University of Michigan Medical Center. The approach was first suggested by LeRoy Abbott who was serving as visiting professor of orthopaedic surgery at that time in a young woman with an "aggressive" giant cell tumor which had virtually destroyed the bodies of C5 and C6. To the author's knowledge, this woman historically represents the first individual treated by cervical spine fusion through the anterior route. The surgical approach is not new, but has long been employed in other surgical problems; e.g., draining retropharyngeal abscesses, gaining access to the upper end of the esophagus. Freiberg[5] only recently told the author of having removed large spurs from the anterior aspect of the cervical vertebra which had been causing dysphagia in 1936 through this approach.

Technique

The majority of anterior cervical fusions first performed at University Hospital were in unstable fractures and fracture dislocations of the cervical spine. As a result, the operations were performed with the patient on a Stryker frame or Foster bed with skull tongs traction in place. More recently, when the anterior approach has been employed in problems not related to structural stability, traction is not necessary. The Foster bed or Stryker frame has been routinely employed, however. The operation is performed with the patient supine on the dorsal frame. This has been found ideal for the operation itself and has been of real value as a means of immobilization postoperatively, and simplifies nursing care during the early postoperative period.

The operative incision lies along the anterior margin of the right sternocleidomastoid muscle. The right side has been preferred to the left although in a few instances the approach has been from the left side. Divergence of the trachea to the left and the presence of the thoracic duct on the left makes this side less attractive. A longitudinal incision has been employed most frequently, although in a few instances a transverse incision through the skin has been used in hopes of achieving a less noticeable scar. The longitudinal incision, however, has not resulted in an unacceptable scar costmetically, and in the majority of these operations longitudinal exposure of the cervical vertebrae has been the objective and would be limited with use of a transverse skin incision (Figs. 1 and 2). This approach has been reported also by Robinson, Smith and Southwick.[8,12,13]

From the University of Michigan Medical Center, Ann Arbor, Michigan.





The Author
R. W. BAILEY, M.D.

The incision has varied in relation to the area of the spine which has been approached. The carotid tubercle can be palpated and serves to identify the level of the sixth cervical vertebra. The angle of the

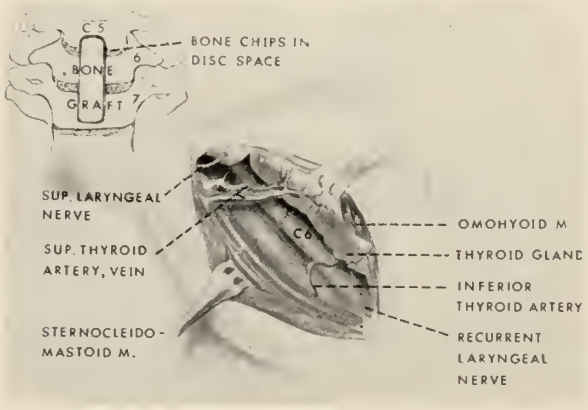


Fig. 1. Technique of anterior cervical fusion. Incision along anterior border, right sternocleidomastoid. Middle thyroid vein has been ligated. Anterior neck structures are retracted to the left exposing prevertebral fascia and anterior aspect vertebral bodies. Inset demonstrates author's thrust bone graft technique.

mandible with the cervical spine slightly extended is at the level of the second cervical vertebra. The suprasternal notch lies anterior to the junction of the seventh cervical and the first dorsal vertebra. The location of the incision will depend on the area of pathology to be dealt with.

The anterior layer of the cervical fascia fuses along the anterior border of the sternocleidomastoid and is incised. The omohyoid transverses the lower portion of the incision obliquely and can be mobilized and retracted distally, or divided and ligated. The pulsating carotid artery is observed pulsating and the middle thyroid vein is identified crossing the wound lateral to medial, lying on the middle layer of the cervical fascia. The middle vein is clamped and ligated. This is usually the only significant vessel divided in approaching the mid-portion of the cervical spine. In approaching the upper cervical vertebrae, the superior thyroid artery and vein must be identified. They lie just deep to the middle layer of the cervical fascia, and as this layer is divided, care must be exercised to avoid injury to these vessels. Rather than retracting the superior thyroid vessels, they are ligated and divided. Slightly deep and cephalic to the superior thyroid artery and vein is the superior laryngeal nerve which supplies sensation to the larynx. Although this structure could be divided without serious consequence, it has not been found necessary to do so. In one case in which biopsy of a destructive lesion of the body of C2 was performed, the glossopharyngeal nerve was identified in the upper reaches of the incision and retracted without difficulty.

In approaching the lower cervical and upper dorsal vertebrae through the anterior approach, the inferior thyroid vessels which also lie deep to the middle layer of the cervical fascia may interfere with exposure and should be ligated and divided. The recurrent laryngeal nerve maintains an intimate relationship to the inferior thyroid artery and damage to the nerve must be avoided.

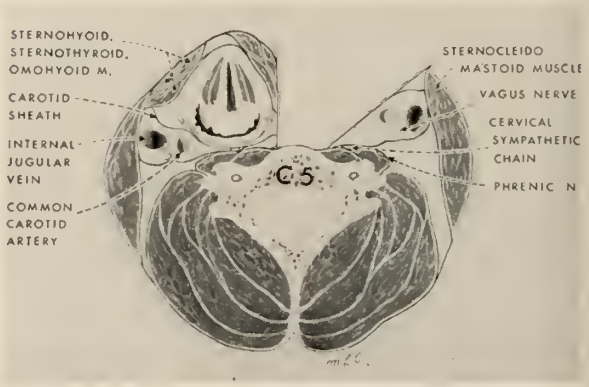


Fig. 2. Cross section of neck at level of sixth cervical vertebra demonstrating route of approach. Note location of carotid sheath and its contents.

After the middle cervical fascia has been incised, the retropharyngeal space is gently entered with a finger and dissection of the anterior neck structures is easily achieved because of the loose areolar arrangement in this space. The trachea is easily identified by presence of an endotrachial tube and the muscular esophagus can usually be seen. The anterior neck structures are retracted to the left side and the carotid sheath and its contents gently retracted to the right. The anterior aspect of the cervical vertebrae are now easily seen covered over by the longus colli muscles and the prevertebral fascia.

Orientation as to the exact vertebra can be achieved in two ways. First, by identification of the carotid tubercle on the costotransverse process of the sixth cervical vertebra. Secondly, by blunt dissection, the base of the skull can be identified in the retropharyngeal space and just below it the anterior bony ring of the first cervical vertebra. By counting down by means of palpation, localization of a given vertebra can be achieved. Accurate localization is confirmed by a lateral roentgenogram made after a drill has been

inserted a short distance into one of the vertebral bodies.

The prevertebral fascia and longus colli muscles are mobilized off of the anterior aspects of the vertebral bodies by sharp dissection. It is imperative that the incision be made at the anatomical mid-line which is easily identified to avoid damage to the cervical sympathetics which lie laterally in the substance of the longus colli muscles. By keeping dissection sharply to bone, damage to the sympathetics can be avoided. In early experiences, stripping the longus colli muscles from the vertebral attachments with an elevator was associated with moderate bleeding. More recently by carrying out this phase of the dissection with an electrocautery this problem has been solved.



Fig. 3. R.S. (A) 18-year-old boy, diving accident, August, 1959, with incomplete paralysis of lower extremities but complete paralysis of hands and loss of bowel and bladder function (represents the acute central cord compression syndrome described by Schneider). Laminectomy considered contraindicated. (B) Three years postoperative anterior cervical fusion C2-4. Has made complete neurological recovery.

The usual manner in which fusion has been performed has been by removing the intervertebral discs between the vertebra to be fused and cutting a trough into the anterior aspects of the bodies to be fused. A bone graft is obtained from the iliac crest and fashioned to accurately fit into the vertebral body trough. Cancellous chips are carefully placed into the intervertebral disc spaces.

In problems of anterior cord compression due to a large osteophytic spur projecting from the posterior portion of the intervertebral disc space into the spinal canal the Cloward[3] technique has been advantageous. Its use was suggested to the author by Taren.[14] The designated intervertebral discs are accurately identified radiologically and using the Light-Velley drill, a hole is cut from anterior to posterior through the disc space and contiguous vertebral bodies. The posterior boundaries of the disc and vertebral bodies are identified through the hole with great care and the remaining disc material, the bony spur and contiguous posterior vertebral body wall are removed with small Kerrison rongeurs. Decompression is accomplished when one can identify only posterior longitudinal ligament through the hole. A bone graft of a size slightly larger than the diameter of the hole is cut from the ilium with a circular saw and measures about 3/16 inch less than the anterior posterior width of the vertebral body. Distraction at the disc space is accomplished by traction on the head and the bone graft is tapped into the hole flush with the anterior aspects of the vertebral bodies.

Whichever technique of bone graft is employed, the prevertebral fascia and longus colli muscles are approximated over the anterior aspects of the vertebrae further securing the graft in place. The retropharyngeal space is drained by means of a medium sized Penrose drain and the wound closed by approximating the superficial layer of cervical fascia and platysma. The skin is closed in routine fashion with the drain emerging at the lower pole of the incision.

Fractures and Dislocations

The indications for cervical fusion in certain fractures and dislocations is quite clear and has been emphasized by Badgley, Gallie, Cone and Turner, Rogers,

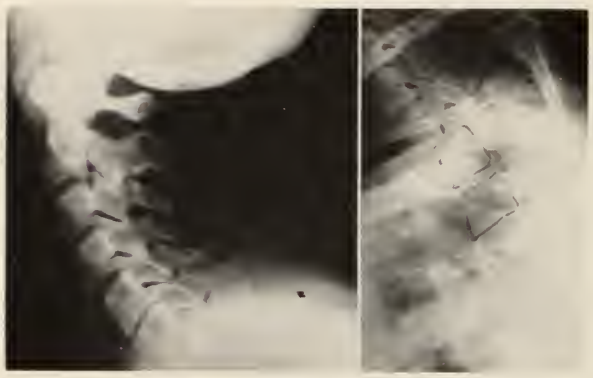


Fig 4. R.D. (A and B) August, 1960. 51-year-old man with C7-8 nerve root involvement bilaterally. Laminectomy by Schneider to decompress nerve roots. Subsequent anterior fusion to achieve stability done C6-D1.



Fig. 5. R.J. (A and B) March, 1956. 17-year-old boy, six months post-diving injury and laminectomy. Complete spastic quadraparesis level C7 with preservation C6 roots making rehabilitation of hand possible (Nickel). Dynamic films demonstrate abnormal mobility C4 and C5. Anterior fusion done at Rancho Los Amigo, 1956, to provide stability and prevent possible damage to remaining nerve roots.

the author and others.[1,2,4,6,9,10] In certain instances, posterior spinal fusion is technically difficult and hazardous, and anterior cervical fusion is preferable (Fig. 3 A and B). Some circumstances under which anterior cervical fusion have proven of distinct value in treatment of fractures and dislocations of the cervical spine are as follows:

1. Following cervical laminectomy which has been done for decompression of trauma to the cord: Frequently, the neurosurgeon may choose to leave the dura open and under such circumstances anterior fusion done at a later time would appear superior (Fig. 4 A and B).

2. Fracture dislocations of the cervical spine associated with severe maxillo facial injuries: This combination not uncommonly results in severe compromise of respiratory function. Under these circumstances, the anterior route offers an easier and safer way of maintaining an airway during surgery. The operation is performed with the patient supine rather than prone which is of considerable help to the anesthesiologist. Furthermore, if at any time any disturbance of respiration is present, a tracheotomy may readily and easily be performed.



Fig. 6. R.G. Three years post-anterior cervical fusion and reconstructive surgery on hands finds him totally self-sufficient and a recent college graduate.

3. For stabilization of the old fracture-dislocation with instability of the spine and quadraplegia: Such instability may threaten the remaining intact nerve roots to the upper extremities which may be of tremendous importance to the rehabilitation of the individual (Fig. 5 A and B and Fig. 6).

4. For the stabilization of fracture dislocations of the spine associated with osteoarthritis: Posterior arthritis spur formation if progressive at the site of fusion might later cause disturbance of cord function requiring laminectomy. The "tear-drop" fracture described by Schneider and Kahn[11] would fall in a similar category and is best treated by anterior fusion, permitting later laminectomy and division of the dentate ligaments of the spinal cord when necessary (Fig. 7 A and B).



Fig. 7. R.V. (A) 1961. Unsuccessful attempt at suicide by hanging. "Tear drop" fracture as described by Kahn and Schneider. Note posterior displacement of the inferior portion of the body of C5. Patient showed incomplete quadraparesis. (B) One-and-a-half years following anterior cervical fusion. Some persistence of bony encroachment of posterior inferior portion of C5 on the neural canal is noted. Neurologic recovery was complete. Laminectomy may later be necessary, however, if neurological findings recur.



Fig. 8. L.S. (A) April, 1952. 21-year-old girl gradually developing quadraparesis with severe neck pain. Biopsy revealed an "aggressive giant cell tumor." Posterior fusion done and extension of tumor into neural arch found. Tumor incompletely removed through anterior approach exposing anterior aspect of spinal cord. (B) One-and-a-half years following anterior fusion with a thrust rib bone graft from C3-6. Shortly following anterior cord decompression, all neurological findings disappeared. Patient succumbed almost two years following anterior fusion due to local recurrence of tumor and spinal cord involvement.

Tumors of the Cervical Vertebral Bodies

The anterior approach has found use in biopsy of destructive lesions of the cervical vertebral bodies. These have included an aggressive giant cell tumor which had extensively destroyed the bodies of the fifth and sixth cervical vertebrae, metastatic neoplasms and a solitary plasma cell myeloma (Fig. 8 A and B).

Infections of the Cervical Bodies

Experiences with anterior fusion for infections of the cervical bodies has not been common, chiefly because of the general decline of tuberculosis of bone in this country. Hodgson[7] in Hong Kong has found anterior fusion very advantageous for tuberculosis in the cervical area. Three patients with infections of the cervical bodies have been treated by anterior fusion—one with tuberculosis, and two with Pseudomonas Aeruginosa.

"Spontaneous" Dislocations After Extensive Prior Laminectomy

A factor not commonly recognized which may result in dislocation of the cervical spine is extensive laminectomy. Dislocation has occurred within a period of a few months to twenty-five years after extensive laminectomy (Fig. 9 A and B). Occasionally it is necessary to remove not only the laminae, but also portions of the interarticular facets to effect removal of a tumor of the cervical spinal cord or remove an extruded intervertebral disc. With loss of these posterior supporting structures, dislocation may later occur producing pain plus neurological findings. In view of such complications, a patient with an extensive laminectomy should be carefully observed for a spontaneous dislocation. If clinical or roentgenographic evidence of dislocation appears as shown on dynamic flexion-extension roentgenograms, fusion must be considered to protect the spinal cord and nerve roots from damage. Anterior cervical fusion offers obvious advantages under such circumstances.

Degenerative Arthritis

Neck pain associated with severe brachialgia may be on the basis of degenerative cervical arthritis. Experiences gained with anterior cervical fusion suggest that this procedure may be of great aid in offering permanent relief to these individuals. Over fifteen patients with degenerative arthritis and brachialgia have been so treated without failure to achieve complete symptomatic relief. Extreme care has been exercised in selection of the patients for this operation. The criteria used in advising operation has been objective evidence of cervical nerve root irritation established by clinical and/or electromyographic means, failure to respond to conservative treatment with cervical traction, a collar splint and analgesics, and the presence of distinct roentgenographic changes consisting of narrowing of the intervertebral disc space or spaces, marginal lipping of the contiguous vertebral bodies, and frequently encroachment of osteophytic spurs on the intervertebral foramina. Myelography has been performed to exclude abnormalities of the spinal cord such as tumor. Frequently, the myelogram shows indentation of the dye column at the level of the bony spurs along the posterior aspect of the vertebral bodies at the level of the intervertebral disc spaces. In the earlier cases, fusion was performed by creation of a

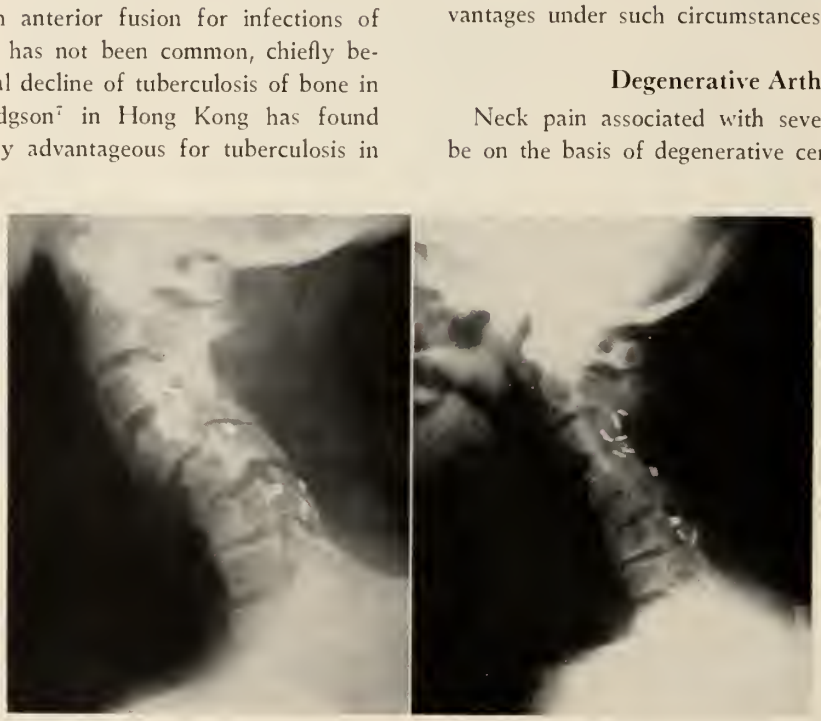


Fig. 9. E.M. (A) 1956. Twenty-five years prior, a large cervical meningioma of the spinal cord was removed by means of extensive laminectomy. During the year prior to this film, gradual recurrence of quadraparesis developed. Note with flexion C4 displaces anteriorly on C5. Believe neurological findings are due to traction on cord caused by the subluxation. (B) Four years post-anterior cervical fusion. Patient has made complete neurological recovery through achievement of spinal stability.

trough as shown in Figure 1. Recently, the Cloward technique has been selected as already described. As one approaches the posterior longitudinal ligament, the spurs are carefully removed using an upbiting Kerrison



Fig. 10. L.J. 1958. One year postoperative anterior excision of degenerative cervical disc between C5 and 6. In recent cases, Cloward's technique has been employed removing osteophytic lipping posteriorly, contiguous to the disc space.

rongeur exposing the posterior longitudinal ligament. If only one disc space is being treated, an iliac graft, the diameter of the hole and about $\frac{3}{8}$ inch deep, is sunk into the hole flush with the anterior aspects of the vertebral bodies. If two or more disc spaces are treated, a trough is created joining these holes and a thrust bone graft inserted as originally described by the author.

Lesions of the Intervertebral Disc

In degenerative or post-traumatic lesions of the intervertebral disc, anterior cervical fusion has a distinct place. Decision for operation is not as precise and recommendation for operation must be predicted on a highly individual basis (Fig. 10). Roentgenograms must be relied on heavily and correlated with the entire clinical picture. Myelograms are routinely done. When true herniation of the intervertebral disc is demonstrable on myelography, it is the author's opinion that laminectomy should be done to allow for more adequate decompression of the cord and nerve roots. By the posterior approach, visualization can be more precise and decompression can be certain. Should bleeding occur, it can more adequately be controlled by electrocoagulation of the vessels against bone.

Summary

Anterior cervical fusion of the cervical spine has developed as a valuable means in treatment of a variety of pathological conditions in this area. Since 1952, the indications for stabilization of the spine by anterior fusion have broadened with increasing knowledge and experience in application of this technique.

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Open Heart Surgery in Infants

Results in Sixty-eight Patients

Herbert Sloan, M.D.
Joe D. Morris, M.D.
Aaron Stern, M.D.
Joan Sigmann, M.D.

Ann Arbor, Michigan

THE CHALLENGE presented by the surgical correction of intracardiac defects in tiny, desperately ill infants, who will not survive without operation, has not been substantially lessened by the experience which has produced the excellent results achieved with older patients. By the end of 1962, open-heart operations with the aid of extracorporeal circulation had been performed for congenital and acquired cardiac lesions on more than 750 patients at the University of Michigan Medical Center.[1] Among these patients were 68 infants two years of age or less. The problems encountered in our attempts to care for these infants have resulted in the development of equipment and techniques which make open-heart surgery for these small patients less difficult and thus reduce the danger to them of operation.

Selection of Patients and Operations

It is desirable to avoid open-heart operations for infants less than two years of age, but we always consider operation for the infant with a correctable cardiac lesion when it is believed he will not survive without operation. Perfusion is much more difficult in these patients and care of the infant after operation is a far greater problem, so it is better to postpone the operation whenever possible until the infant is older and larger. Tragically, waiting has brought death to some of these infants, while early operation at least offers a chance and has saved many of them.



The Author
HERBERT SLOAN,
M.D.

Most of these infants requiring correction of intracardiac defects have large left-to-right shunts with severe pulmonary hypertension. Heart failure with a marked increase in heart size is present in the majority of these infants and continuing respiratory infections make repeated hospitalizations necessary. In a few patients with atrial defects and endocardial cushion defects resulting in large left-to-right shunts, operations have been indicated in infancy to save life or to prevent repeated hospitalizations.

The proper care of infants with large ventricular defects is a disturbing problem. Some of these infants develop severe symptoms early in life and the mortality rate in this group is high.[2,3,4] Since many such infants will not survive with non-surgical management, some operative procedure must be carried out to reduce the excessive pulmonary blood flow. Direct repair of the ventricular defect would be the treatment of choice if the operative mortality were not prohibitive.[5] Pulmonary artery constriction has been advocated as a palliative measure to reduce pulmonary blood flow and to allow the infant to develop to a point where closure of the ventricular defect can be carried out safely.[6,7] Not many of these infants have as yet undergone closure of the ventricular defect after pulmonary artery constriction so the risk associated with the second operation is not known.[8] It is our practice to advise direct repair of the ventricular defect for all infants whose life is threatened and who may not survive infancy without operation.[9]

Successful open-heart operations cannot be carried out on infants with ventricular defects in whom there is severe pulmonary hypertension and a predominately right-to-left shunt, so that systemic flow is greater

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From the Department of Surgery (Section of Thoracic Surgery) and the Department of Pediatrics, University of Michigan Medical Center, Ann Arbor, Michigan.

than pulmonary flow. Catheterization findings suggesting right-to-left shunts in infants must be interpreted with care, however, since both sedation and cardiac failure may give findings which indicate a right-to-left shunt when none is present.

When the infant less than two years of age with tetralogy of Fallot requires surgical treatment, a shunt procedure or an infundibular resection is the best choice, with complete correction postponed until a later date. The tiny infant with pulmonary valve stenosis may require operation but is sometimes too ill to allow the dissection necessary for cannulation and correction under direct vision with extracorporeal circulation. A transventricular pulmonary valvulotomy is carried out for these infants.

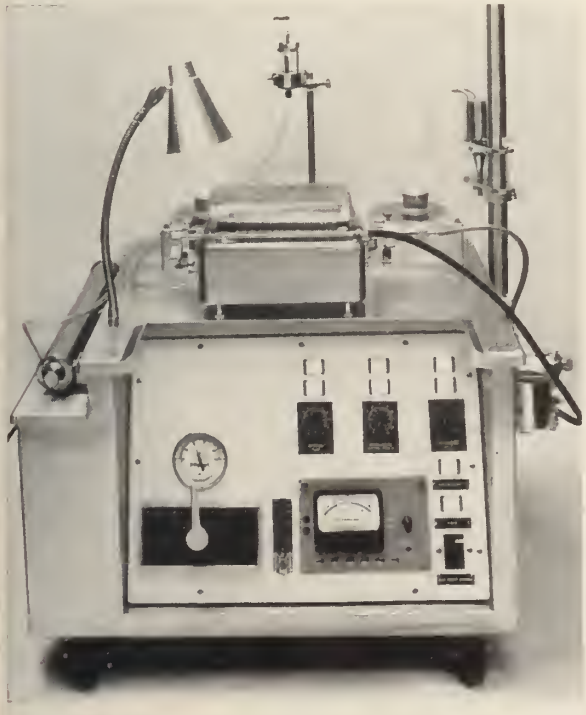


Fig. 1. Miniaturized equipment for extracorporeal circulation in infants.

Most infants with complete transposition of the great vessels do not survive. Total correction of this anomaly is usually impossible in infants and an operation for partial correction is advisable. In our procedure, a baffle is placed within the atrium to divert the return from the right lung and the inferior vena cava into the systemic ventricle. Total anomalous pulmonary venous drainage may also threaten the life of the infant and correction at an early age may be required. Open correction of aortic stenosis may be necessary in infancy in rare cases.

Perfusion Technique

Open-heart surgery in infants requires far gentler handling of the heart and much more exact control of the perfusion than is necessary with older children and with adults, although the concepts and the techniques are the same. Deviations from the ideal may be relatively harmless to larger patients, but they will almost certainly result in the death of infant patients.[9]

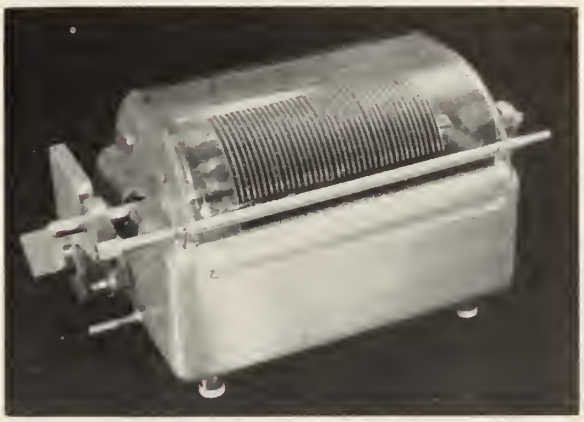


Fig. 2. 32-disc infant oxygenator. Volume of oxygenator can be reduced as desired.

Our perfusion equipment for infants is a result of a continuing struggle to develop an extracorporeal circuit scaled to the size of the patient which allows exact control of the perfusion. The equipment also reflects our attempts to accomplish cannulation of the infant quickly and safely, and to provide adequate amounts of oxygen with least damage to the blood during the perfusion. It has been constructed for use with a standard pumping unit or with a modified unit designed especially for infant perfusion* (Fig. 1). The perfusion equipment consists of a receiving chamber, a rotating disc oxygenator, a heat exchanger, and a bubble trap. There is no filter in the circuit. Tygon tubing is used to connect the elements of the extracorporeal circulation to each other and to the patient. All parts of the unit can be autoclaved. Blood is removed from the body by gravity drainage through catheters or metal cannulas placed through the right atrium into the superior and inferior venae cavae. The oxygenated blood is returned to the body through a metal cannula in the left femoral artery.

A 32-disc oxygenator (Fig. 2) is used for infants weighing 10 kilograms or less and will perform satisfactorily with flow rates up to 1.5 liters per minute. A half cylinder seamless steel pan, 7 cm. deep

*Constructed by Sarns, Inc., Ann Arbor, Michigan.

serves as a reservoir for the blood. The pan is covered by an autoclavable plastic canopy (Lexan). The stainless steel discs, 12.5 cm. in diameter and 0.5 mm. in thickness, are mounted on a hexagonal shaft to

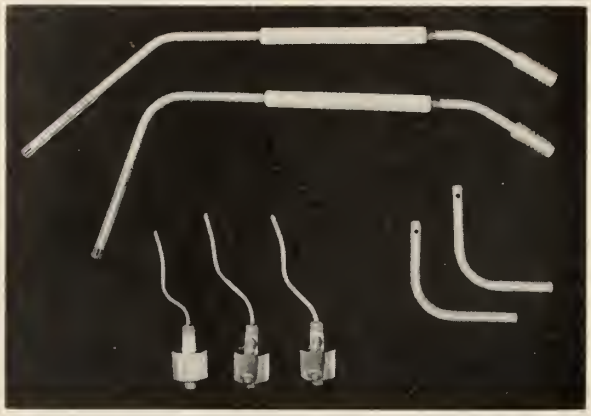


Fig. 3. Small aspirating tips, arterial cannulas, and venous cannulas for infant perfusions.

prevent slipping of the discs and are separated by spacers, 4.5 mm. thick. The oxygenator shaft rests on adjustable outboard bearing mounts attached to the end of the oxygenator pan. The outlet trap of the oxygenator is a 5 cm. cylinder extending vertically below the pan surface; the outflow leads off at a right angle from the cylinder. A major advantage of the oxygenator design is the ease with which it can be disassembled and cleaned. All surfaces are highly polished and corners and seams have been eliminated. Every part of the oxygenator can be easily reached for cleaning.

A miniaturized single receiving chamber accepts the venous inflow into the circuit. Aspirated blood from the heart is returned to the upper portion of the receiving chamber, which contains a plastic sponge lightly coated with Antifoam to remove bubbles. A small torpedo type heat exchanger and bubble trap in the arterial line complete the circuit.

The cannulas for the venae cavae are right-angled, thin-walled, stainless steel tubes 4.3 mm. in internal diameter. For larger infants, catheters of 16 to 20 French size are employed. The arterial cannulas, sized 2.0 mm., 2.5 mm., are placed through the femoral artery into the iliac artery. Their shape allows these cannulas to follow the contour of the pelvis and it has been possible to perfuse infants satisfactorily through the femoral artery. Small aspirating tips, modified from those described by Cross,[10] allow removal of blood from the heart without obscuring visibility (Fig. 3).

The entire circuit has a priming volume of 1,500 ml. of blood. With this amount the reserve capacity in the system is large enough to handle sudden blood loss during perfusion and yet allow accurate measurement of the volume of blood in the extracorporeal circuit. It has been suggested that the amount of blood in the extracorporeal circuit may have a deleterious effect on the perfused patient.[11] To reduce the volume of blood in the extracorporeal circuit employed for very small infants, the number of discs in the oxygenator can be decreased to any number desired and a bulkhead placed in the oxygenator to diminish still further the amount of blood required for priming of the circuit.

Fluothane (halothane) is the preferred anesthetic agent for these infants and is supplied directly to the oxygenator during perfusion from a vaporizer mounted on the side of the pumping unit. Muscle relaxants are avoided and every effort is made to have the infant awake and responsive upon completion of the operation. The gas mixture employed in the oxygenator is 98 per cent oxygen and 2 per cent carbon dioxide. The discs are rotated at a rate of 100 revolutions per minute but may be slowed 80 revolutions per minute when hypothermic levels are reached. Heparinized blood for the extracorporeal circuit is drawn the morning of operation.

The heart is exposed through a median sternotomy incision and the venae cavae and aorta are isolated within the pericardium. Heparin is administered in a dose of 3 mg. per kilogram of body weight and, during the perfusion, an additional one-third dose of heparin is injected into the extracorporeal circuit every 45 minutes. The heparin is neutralized at the end of the perfusion with an equivalent amount of protamine.

Perfusions are combined with moderate whole body hypothermia at an esophageal temperature of 28 to 30 degrees centigrade. Surface cooling is started on a water mattress at the beginning of the operation. The body temperature of most infants has reached 32 degrees or 34 degrees centigrade by the time preparations for heart-lung bypass are made. Additional cooling is accomplished easily with a heat exchanger while the intracardiac lesion is exposed and examined. Intermittent aortic occlusion for not more than ten minutes at a time is employed when necessary to improve exposure of the lesion. For more difficult operations, the esophageal temperature is lowered to 20 degrees centigrade or below, allowing periods of complete interruption of the circulation.

Rewarming with both the heat exchanger and the water mattress starts when the intracardiac repair is complete, and the perfusion is discontinued at an esophageal temperature of 37 degrees centigrade and a

rectal temperature of 35 degrees centigrade. Because infants tend to lose heat during operation it is preferable to raise the body temperature to nearly normal levels before discontinuing the perfusion. The drop in temperature frequently seen following perfusion will not then reach dangerous levels. When ventricular fibrillation has occurred during hypothermia, spontaneous defibrillation often follows when the blood perfusing the heart reaches a temperature of 30 degrees centigrade; if this does not happen a single electric shock will defibrillate the heart at this temperature.

Moderate whole body hypothermia during perfusion improves exposure by reducing greatly the amount of pulmonary venous and coronary sinus blood returning to the heart. Less trauma to the blood is incurred during long perfusions, and the patient's condition afterwards seems to be better, since appropriate hypothermia became part of the procedure. Decompression of the left side of the heart has largely eliminated pulmonary congestion following perfusion. This is accomplished with an aspirating tip placed in the pulmonary artery when the right ventricle is opened, or by a sump in the left atrium. The lungs are kept half inflated with oxygen during perfusion, but they are not ventilated.

Flow rates during perfusion in infants are sufficient to maintain a mixed venous oxygen saturation of 60 per cent or more, although this may not be a valid indication of adequate oxygenation under hypothermic conditions. Relatively high flow rates averaging 95 milliliters per kilogram of body weight per min. are considered important even in the presence of moderate hypothermia. These flow rates are considerably greater than the necessary calculated flow rates at temperatures of 28° to 30° C.[12] Mean blood pressures of 70 to 100 millimeters of mercury are consistently maintained. Most perfusions are continued for 30 to 60 minutes, although a perfusion lasting 110 minutes was successfully accomplished in a tiny infant.

Careful monitoring of the patient's physiologic condition, before, during and after perfusion is essential. The electrocardiogram and the electroencephalogram are recorded. Arterial and venous pressures are measured through small polyethylene catheters placed in the right femoral artery and saphenous vein. The monitoring catheters are inserted as soon as possible after the operation starts since cuff blood pressures are difficult to obtain in infants and are not reliable. The blood pressure of sick infants with serious cardiac abnormalities may fall to shock levels soon after anesthesia is induced. This circulatory failure before perfusion is probably the cause of some deaths following operation, so it is important that the blood pressure be known and that the pressure be supported with vasopressors when it falls. Esophageal and rectal temperatures are recorded, as well as the temperature of the arterial blood entering the patient. Oxygen saturations of arterial and mixed venous blood are determined intermittently during the perfusion.

The amount of blood introduced into the extracorporeal circulation is measured accurately and the amount remaining at the end of the perfusion is measured again. Blood lost during operation is calculated by collecting all blood aspirated, by weighing sponges, and by estimating blood loss on the surgical drapes. These values, together with the amount of blood administered intravenously, allow an immediate estimate of the patient's blood loss and the replacement required. This method has made it unnecessary to weigh the patients after operation for the purpose of determining blood replacement. Venous pressures are followed carefully during and after perfusion but continuous and accurate information about loss and replacement and careful monitoring of the blood levels in the oxygenator provide more sensitive information about the circulating blood volumes of the infant before, during, and after perfusion. It is, of course, extremely important that the perfusion be completed with the patient's blood volume unchanged.

Acid-base studies carried out on these infants during perfusion at levels of moderate hypothermia have paralleled determinations made in older children and adults when the values are corrected for the patient's temperature.[13,14] The infants develop respiratory alkalosis combined with mild metabolic acidosis. The techniques of perfusion supply adequate amounts of oxygen to the tissues. Metabolic acidosis of a significant degree has not occurred, and it has not been necessary to add base during the perfusion.

Care of Infants Before and After Operation

The survival of infants after intracardiac operations depends as much on the care the infant receives before and after operation as on the operation itself. In our hospital, postoperative care is carried out in a unit equipped and staffed to meet the special problems of infants who have undergone a cardiac operation. As with older patients,[15] the procedures are designed to offer maximum support to the patient and prompt warning of impending complications. It must be emphasized, however, that with infant patients the margin for error is much narrower, and any departure from ideal care is more likely to be followed by catastrophe. Before operation, it is desirable that the infant be as free of respiratory infection as possible. Most of

the infants are given digitalis, with careful attention to correct adjustment of the dosage. In some cases, however, there is no ideal time for operation and an attempt must be made to correct the cardiac lesion in the face of progressive heart failure and respiratory complications.



Fig. 4. Prone position to improve bronchial drainage following open-heart surgery in infants.

The problems of postoperative care for infant patients fall into certain categories:

1. Ventilation and secretions
2. Blood and fluid replacement
3. Circulatory failure
4. Disturbances of cardiac rhythm
5. Cerebral damage
6. Disturbances of acid-base balance

1. *Ventilation and Tracheobronchial Secretions.*—Pulmonary secretions increase after open-heart surgery and their control in infants presents special problems. Pulmonary complications are less frequent since the adoption of the median sternotomy incision and since the importance of decompression of the left side of the heart has been understood. Recognition of retained pulmonary secretions is difficult by physical examination alone; portable chest roentenograms, however, supply the necessary information. Such examinations are made in the operating room and during the evening on the same day. Additional examinations are made during the next three days.

The infants are placed in an oxygen enriched atmosphere with high humidity. Although intratracheal suction would help to clear the tracheobronchial tree, it is difficult to accomplish in the infant; pharnygeal stimulation, however, usually produces effective involuntary coughing. Persistent but unsuccessful attempts to aspirate the trachea are tiring to both patient and staff, and the value of this assistance may be offset by the infant's need for adequate rest. Bronchoscopy has not been used for our patients, but exposure of the larynx and direct aspiration of the trachea with a rubber-tipped sucker has been of value.

Secretions can be mobilized by changes in posture so the infants are turned from side to side every half hour. Most infants prefer to sleep prone or in the knee chest position and every effort is made to promote bronchial drainage by this means (Fig. 4). Experience gained by Dr. Cameron Haight in the care of infants with esophageal atresia has been of great value in handling the pulmonary problems of infants following intracardiac operations.[16] Tracheostomy is seldom used now, and is resorted to only when secretions are not controlled or respiratory exchange is not adequate with routine procedures. The mechanical respirator has not been of great help in infants requiring respiratory assistance. In most cases the infants have died, although there have been enough exceptions to justify the use of the respirator when it is needed.

2. *Blood and Fluid Replacement.*—Restoration of the clotting mechanism is a fundamental requirement for the success of the perfusion. Protamine has proved a satisfactory drug for this purpose; postoperative bleeding as a result of clotting defects has been rare. If the preoperative bleeding and clotting times are normal, no other evaluation of the clotting mechanism is necessary unless a history of bleeding has been obtained.

To establish drainage, the pericardium is left widely open during operation. Whenever possible the pleural spaces are not opened and the mediastinum alone is drained with a small catheter. When the infant is returned from the operating room his blood volume is approximately his preoperative blood volume. A miniaturized and calibrated thoracotomy jug is used to collect the drainage fluid; the amount is measured carefully each half hour so that the fluid can be replaced volume-for-volume by fresh whole blood. Reexploration for bleeding has not been necessary in this group of patients. In rare cases an additional dose of protamine, equivalent to one half the amount of heparin used, may be desirable. Drainage fluid from the chest becomes serous in a few hours in most infants, and the volume of drainage corresponds to that from a thoracic operation without perfusion.

In our infants significant anemia has not been ob-

served during the postoperative period. In the first 48 hours there is slight hemoconcentration which is corrected as fluid intake increases. This hemoglobin level continues until the patient's discharge ten days to two weeks later.

Following operation, the infant's blood pressure, pulse rate and respiratory rate are recorded at 15-minute intervals for the first eight hours and then at decreasing intervals until the patient leaves the cardiac unit. Most infants have required no other special observation of the circulation.

Limitation of fluid intake has contributed to the reduction of pulmonary complications. Fluid intake is based on weight rather than surface area because surface-area standards in infants are not reliable.[17] The infant is allowed 40 to 55 milliliters of fluid per kilogram of body weight during each of the first two twenty-four hour periods following operation. The ACD solution in the citrated blood administered is included as a part of the fluid requirement. Small amounts of fluid are allowed by mouth on the day of operation, and thereafter as much of his fluid requirement as the infant can tolerate is given by mouth. Any deficit in fluid intake is made up by the intravenous administration of 5 per cent glucose in 0.2 per cent sodium chloride. Additional restriction of fluid intake is determined by the degree of heart failure before operation and the infant's condition during the postoperative period.

Although the weight of the infant is not used as an index to blood loss replacement, daily recording of the weight assures recognition of fluid retention and impending heart failure. Attempts are made to collect and measure all urine output. Most of the infants void a small amount of concentrated urine the day of operation; diuresis occurs the day after the operation and thereafter urine output is normal. In our series of infants renal shutdown has not occurred.

3. *Circulatory Failure.*—The state of the infant's peripheral circulation constitutes the most important evidence of his condition following open-heart surgery. The use of indwelling catheters to follow arterial and central venous pressures and to measure oxygen saturations and acid-base changes provides helpful data in infants with precarious circulatory status following operation. Measurement of central venous pressures following operation is a senstive index of hypovolemia and of heart failure but is not always helpful in problems of inadequate circulation.

Inadequate peripheral circulation, even wtih relatively good central arterial pressure, is a very grave sign. Poor circulation caused by hypovolemia may be corrected by the administration of blood when the central venous pressure is low. Poor ventilation is occasionally the cause of failing circulation; aspiration of tracheobronchial secretions improves circulation dramatically in such cases. In most of our infants, inadequate peripheral circulation is the result of severely increased pulmonary resistance or of inadequate correction of a complicated intracardiac anomaly. Cooling of the infant may produce peripheral vasoconstriction and cyanosis which simulate failing circulation. Rectal temperatures are monitored continuously and efforts are made to maintain a normal temperature.

Hypoxia resulting from poor peripheral circulation leads to increased metabolic acidosis which in turn potentiates the circulatory failure. Improved ventilation and the administration of vasopressors and base may bring temporary improvement, but the underlying abnormality must be corrected. The catastrophe of sudden death has occurred only in those infants with inadequate cardiac output and failing peripheral circulation.

Digitalis has been required by the majority of our infants undergoing open-heart surgery. The drug is always continued after the operation, usually at the preoperative dosage level. No pattern of necessary changes in postoperative dosage has been discerned; usually it is possible to discontinue digitalis before the infant is discharged or the first time he is examined following his discharge.

4. *Disturbances of Cardiac Rhythm.*—In our series of infants, complete heart block as a sequel to the repair of cardiac defects has occurred only rarely. It has seemed related to the degree of cardiac hypoxia rather than to the placement of sutures close to the conduction bundle. Temporary atrio-ventricular dissociation has been seen frequently during bypass with hypothermia, but this has cleared in most infants before the completion of the operation.

5. *Cerebral Damage.*—Brain damage in our infants has been due to air embolism and has occurred only when the systemic side of the heart has been opened either directly or through a septal defect. Air has thus been trapped in the systemic ventricle and ejected into the circulation. The perfusion apparatus has not been a source of air emboli.

Routine aspiration of the systemic ventricle following closure of the heart has resulted in almost complete disappearance of cerebral problems. The infant is

placed in the Trendelenburg position during perfusion so that air collects in the apex of the ventricle where it can be aspirated and cannot enter the aorta. When neurologic signs have occurred as a result of air embolism they cleared before discharge and no infant has shown signs of permanent damage.

6. *Disturbances of Acid-Base Balance.*—Changes in acid-base balance following open-heart surgery are similar to those seen after any thoracic operation. During operation there is respiratory alkalosis and mild metabolic acidosis which change, in the postoperative period when the infant is no longer over-ventilated, to a combined respiratory and metabolic acidosis. Before the operation the infant may show some degree of metabolic acidosis as a result of his severe cardiac abnormality; however, the acid-base balance returns to normal within 24 hours afterward. The postoperative changes noted have not been of clinical importance in our series.

If hypoxia is present or the peripheral circulation fails, increasing metabolic acidosis occurs. Administration of a base corrects the trend temporarily, but improvement can be maintained only if the cause of the acidosis is found and corrected. Survival depends upon adequate ventilation and circulation, and has not been greatly affected by the administration of a base.

TABLE I. RESULTS OF EXTRACORPOREAL CIRCULATION IN 68 INFANTS

	Patients	Deaths	
		Early	Late
Ventricular defect	33	8	0
<1 year old	19	4	0
1-2 years old	14	4	0
Transposition	13	8	2
Atrial defect	3	0	0
Atrioventricular canal	3	1	0
Pulmonary valve stenosis	3	0	0
Total anomalous pulmonary venous drainage	6	4	0
Miscellaneous	7	4	2
Total	68	25	4



Fig. 5. (A) Preoperative chest roentgenogram of eight-month-old infant, weighing 5.9 kilograms, with large ventricular defect, heart failure, and severe pulmonary hypertension. Ventricular defect was closed in October, 1960. (B) Postoperative chest roentgenogram made two years after closure of ventricular defect.

Results

Open-heart operations with the aid of extracorporeal circulation have been carried out in 68 infants, of whom 46 were less than a year old and none was over two years of age (Table I). With increasing experience larger numbers of intracardiac operations are being performed upon infants each year. The smallest infant successfully perfused weighed 2.5 kilograms, the youngest was 12 days old. From the total number, 39 are living; in four of the patients who did not survive, death was not associated with the original operation and perfusion. In each of the 68 cases, there was a serious cardiac abnormality which was considered to be a threat to life.

Thirty-three infants underwent correction of a ventricular defect with eight deaths; nineteen were less than a year old. All of these infants had a history of heart failure and examination showed large left-to-right

shunts. In all but seven, there was severe pulmonary hyptertension, with pulmonary artery pressures greater than 75 per cent of the systemic pressure. A larger number of the infants have survived closure of the ventricular defects as experience has increased and techniques have been refined. Twenty-four of the infants were below the third percentile of weight and the deaths occurred among those with the poorest development. The eight deaths occurred in two groups; four tiny infants weighing less than 4 kilograms, and four older and larger infants with severe pulmonary hypertension, two of whom had balanced or bi-directional shunts. In one of the larger infants who did not survive, heart block was responsible for death, and in another a poor perfusion contributed to the infant's death.

The 25 surviving infants with ventricular defects have been helped greatly by operation, showing significant increases in weight and growth. Heart failure has cleared and respiratory symptoms have been relieved (Fig. 5). Three of these infants have been operated upon a second time successfully for incompletely closed ventricular defects. A number of these infants have cardiac murmurs of uncertain significance.

Results were good in the nine cases comprising pulmonary stenosis, atrial defects and endocardial cushion defects; there was one operative death in this group. Among the six patients with total anomalous pulmonary venous drainage, the pulmonary veins drained into the liver in two and into the coronary sinus or the left superior vena cava in the other four. One infant with coronary sinus drainage and one infant with hepatic drainage of pulmonary veins survived correction of their defects (Fig. 6). The results with complete transposition of the great vessels were not good; only five of 13 infants undergoing partial correction of this anomaly survived operation and two died later. The patients in the miscellaneous group included two infants with aortic stenosis, one infant with a single ventricle, one infant with corrected transposition and mitral insufficiency, one infant with tetralogy of Fallot, one infant with an anomalous left coronary artery, and an infant with a complicated, uncorrectable ventricular and atrial abnormality. Four of these infants survived the original perfusion, but two died during later attempts at additional correction.

In many of the infants there was an associated defect which required recognition or correction for successful operation. These defects included patent ductus arteriosus in eleven cases, atrial defect in four, left superior vena cava in two, and mitral insufficiency in two.

The causes of death following attempts to repair intracardiac lesions were sometimes obscure. In some of the infants, particularly those with transposition, death following operation was related to the complexity of the lesion and the inability to achieve a satisfactory



Fig. 6a.



Fig. 6b.

Fig. 6. (A) 3.7 kilogram infant two weeks following correction of total anomalous pulmonary venous drainage into liver at the age of 12 days. (B) Ten months following operation.

repair. In five cases recorded early in our experience, death followed an obviously poor perfusion or failure to recognize low blood pressure during the early stages of the operation. Heart block was responsible for two deaths, and continuing pneumonitis for two others. Severe pulmonary hypertension contributed to the death of several of these infants.

Fifteen of the seventeen infants weighing less than

4 kilograms did not survive operation. The small size of the infants contributed to the difficulties of achieving satisfactory perfusion, accomplishing correction of the intracardiac defect, and caring for the infant following operation. While many of them were only a few weeks old, their small size frequently was due to the seriousness of the cardiac lesion rather than the age of the patient.

Summary

An extracorporeal circulation especially designed for open-heart operations on infant patients has been developed during the correction of intracardiac defects in 68 patients two years of age or less. There have been 29 early and late deaths in the series, occurring mostly among the smallest infants with the most severe cardiac abnormalities; fifteen of the 17 patients weighing less than 4 kilograms did not survive. Among 33 patients undergoing correction of ventricular defects, there were eight deaths. In many cases there were associated defects requiring recognition or correction.

Although the principles of open-heart surgery and patient care are the same for tiny infants as for older patients, there are technical differences which are vital to the success of the perfusion and the operative procedure. Instruments such as cannulas must be adapted to the diminutive vessels, and those used at the site of operation must be small enough to allow visualization of defects in tiny hearts. The extracorporeal circuit must be designed for highly precise control of blood volumes. With infants there is practically no margin for error in the procedure. In both the operation itself and the postoperative care, deviations from the ideal which might not harm an older patient will almost certainly prove disastrous to the infant.

It is desirable to avoid open-heart operations in patients less than two years of age, but we have always considered operation for the infant with a correctable cardiac lesion when it is apparent that without such treatment he will not survive. Our results indicate that many infants can be saved who might otherwise die while awaiting a more suitable time for surgical treatment.

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Current Clinical Practice and Applied Research in Neurological Surgery In a Medical Center

Richard C. Schneider, M.D.
Elizabeth C. Crosby, Ph.D., Sc.D.
Ann Arbor, Michigan

THE LATE Dr. Max Peet, Professor of Neurological Surgery at The University of Michigan Medical School and Hospital, a pioneer in his specialty, is frequently cited as the prototype of "the master surgeon" of his era. His service had not only a national but also an international tone, for patients came from all over the world for treatment. An atmosphere of charged attention prevailed in the operating room as the spotlight remained focused on the surgeon carefully explaining important facets of the operation to his assistants or some renowned visiting colleague. The deft touch and organized operating routine, which had become second nature to him, enabled control of hemorrhage and rapid completion of a difficult operation. Speed was essential in those days when anesthesia, blood transfusions, hypothermia, steroid replacement therapy, urea infusion, and the many fine present day adjuncts to surgery were unavailable. His surgical teachings and techniques still serve as a background for training fine residents in the specialty. Here, then, was the concept of "the master surgeon."

In many ways, the current practice of neurosurgery is quite different. Fourteen years ago, the first author completed his neurosurgical training under Doctor Peet and Doctor Kahn and embarked upon the private practice of neurosurgery in one of our large cities. Even at that time, it became apparent that the young neurosurgeon would have to make an early decision whether to enter the private practice of neurosurgery as an individual or remain in academic surgery in a large teaching and research center as a member of a trained team.

The neurosurgeon unaffiliated with a teaching center will spend 60 per cent of his time seeing medical neurological problems. He will treat many craniocerebral injuries and ruptured intervertebral discs. In his practice, he will see some spinal cord injuries and operate upon some brain and spinal cord tumors and patients with ruptured aneurysms. However, since he may not have free access to such ancillary techniques as: generalized or regional hypothermia, electrocorticographic and subcortical recordings, electrical cortical stimulation facilities, radioactive localization methods, plastic spraying techniques for treating aneurysms, and the various stereotaxic methods (including the more recent cryogenic or "freezing" techniques) which are now common to many medical centers, he may find it expedient to refer neurosurgical patients requiring such therapy to centers which are more adequately equipped to treat such problems. On the other hand, the neurosurgeon in such a center must not be deluded into the belief that he himself is a "master surgeon" for upon reflection he soon realizes that, if he is fortunate, he is instead an integral part of a well coordinated and skilled team, no single member of which can function without well trained colleagues, not only in surgery but also in related fields. This pattern is not to be construed as a "committee approach" to surgery, but one which requires direction, vigor, and leadership toward a stipulated predetermined goal.

Twelve years ago, the first author of this paper was fortunate enough to be invited by Dr. Edgar A. Kahn, Professor of Surgery and Chief of the Section of Neurosurgery, to return to the Clinical Neurosurgical Staff at The University of Michigan Medical Center and School. Upon retirement as Professor of

The Author
RICHARD C. SCHNEIDER, M.D.



From the Departments of Surgery, Sections of Neurosurgery, The University of Michigan Hospital and Medical School and St. Joseph Mercy Hospital, Ann Arbor, Michigan.

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Anatomy, Department of Anatomy, five years ago, the second author was invited by Doctor Kahn to become associated with the Section of Neurosurgery in charge of the Neurosurgical Research Laboratory. Since that time both authors have been privileged to be associated with Doctor Kahn, the other members of the permanent staff and a fine resident group from whom consultation or aid has been sought frequently and by whom sound advice and able support have been given.



Fig. 1. *(above)*. Case 1. Preoperative photograph taken from a movie which showed the patient's constantly writhing motion, inability to sit alone, and the marked flexion of left lower extremity.

Fig. 2. *(below)*. Case 1. Photograph from a movie taken three weeks postoperatively showing patient sitting alone with control of movements. The left leg still exhibited some lack of extension at the knee at this time. By four months, she walked well, unassisted.

Dr. Basu K. Bagchi, Professor of Electroencephalography, Miss Hazel D. Calhoun, Research Associate in Electroencephalography, and Mr. Henry Pantek, Research Associate in Surgery (Electronics) have also been essential members of this team. Last, but not least, Dr. Robert Sweet and Dr. Guenter Corssen of the Department of Anesthesiology have provided great help with their special talents.

The group has made possible the treatment of many patients with complicated problems which have required collective specialized skills. It is quite apparent that such a team, first and foremost, should render service in the form of patient care, but in achieving this end, should, wherever possible, provide some contribution toward the advancement of knowledge in the neurosurgical field. It is within this sphere that the following case reports are presented as examples of a multiple disciplined effort.

Surgery for Correction of Tremor and Rigidity

Case 1.—A nine-year-old, right-handed girl, B.W., had had progressive impairment of walking and increased difficulty with generalized athetoid movements. She had had contractures of both lower extremities, was increasingly restless, was unable to feed herself, sleep, or carry out basic bodily functions despite moderate amounts of librium and other medications. The patient was in constant writhing motion, flexing and extending both legs, back, trunk, and neck, moving from one end of the bed to the other. The left leg was fixed in knee flexion so the foot rested against the buttock most of the time. Both feet were in equinus posterior position with marked varus deformities. She was unable to stand, walk alone, or scarcely sit unsupported (Fig. 1).

On June 25, 1962, a pneumoencephalogram was made under general anesthesia to identify the foramen of Monro. Using the Bertrand[1] pneumotaxic or snare technique, electrical subcortical stimulation was performed and two lesions were made in the right thalmus, one in the lateral ventral nucleus, and the other in the anterior ventral nucleus by Doctors Brinkman, Singer, and the authors.

Ten days postoperatively, the child could walk, sit without support, feed herself, and the left knee contracture had virtually disappeared. The patient is shown approximately one month postoperatively (Fig. 2). Four months following the procedure, the patient was able to walk without support and was practically free of any involuntary movement. The child will have to be carefully followed to be sure that this status is maintained. If her condition progresses a secondary lesion will have to be placed in the unoperated hemisphere.

Comment.—This case is presented to demonstrate how under *general anesthesia* a precise neuroanatomical lesion may be placed by snare technique in the anterior portion of the ventral nucleus of the dorsal thalamus of a patient suffering from the abnormal movements of musculorum deformans. This amelioration of symptoms was accomplished using the Bertrand[1] modification of Guiot's[10] cauterization technique in the treatment of Parkinsonism patients for relief of tremor and rigidity. It is contrasted to other methods of making lesions under *local anesthesia* until the desired clinical result is achieved. These techniques are: surgical interruption of fiber pathways,[14,24,25] injection of

alcohol (or its derivatives)[2] or procaine solutions.[15] Precise neuroanatomical localization was necessary for success in the case recorded above. There was no danger of spread of the destructive medium, such as alcohol or electric current, with the possibility of neurologic deficit and death. The new cryogenic (freezing) technique recently advocated by Cooper and Lee[3] may surpass all of the older methods of stereotaxic surgery if it is found that the patient's condition does not regress on long term follow-up evaluation.



Fig. 3. *(left)*. Monkey No. 4711 is shown seven months after left superior cerebellar pedunculotomy and three weeks after the second procedure, right hemispheric cortectomy. The animal still was unable to stand or walk but lay on her right side using her left extremities to push herself about in a circle on the floor.

(Reprinted from *Journal of Neurosurgery*.[21])

Fig. 4. *(right)*. Monkey No. 4711 demonstrated ability to walk four months following subtotal right hemispheric cortectomy. Although increased tonus of the left extremities made walking possible the gait was awkward because of the sensory loss in these extremities.

(Reprinted from *Journal of Neurosurgery*.[21])

One of us (ECC) has developed a concept of the existence of the system of checks and balances in the central nervous system which is responsible for normal tonus and smoothly integrated movements in primates.[19,21] The pathways range from the cerebral cortex at one end of this arc through the basal ganglia, thalamus, midbrain, and pontine tegmentum, to cerebellar levels.[4,5,6] If tonus or movement in the individual has been distorted by a primary lesion along this pathway some degree of improvement might be achieved by inserting a secondary lesion in an appropriate site at the opposite end of the scale.

For example, Monkey No. 4711 had a left superior cerebellar pedunculotomy (Fig. 3), and seven months later the animal had a right hemispheric cortectomy (Fig. 4). The monkey had been unable to stand or walk after the first procedure but merely lay on its right side using its left extremities to push itself about in a circle on the floor (Fig. 3), but four months following the second operation the animal could walk again although paretic in the left extremities (Fig. 4).

On the basis of over 300 operations on the monkeys, it was thought that it might be feasible to apply the knowledge gained in the laboratory to a human patient.

Case 2.—G.I., an eight-year-old boy, suffered from erythroblastosis foetalis with choreoathetosis. His neurologic disability was so great that he had to be lashed to a chair to keep from falling to the floor. The slightest stimulus caused his arms to fly upward, his hands became contorted, and severe spasms occurred in the lower extremities throwing them into marked flexion or extension. He had never been able to feed himself. There was marked head movement, facial grimacing, and involvement of the muscles of the

*Condensed and reprinted from *Structure and Function of the Cerebral Cortex*. Ed. by D. B. Tower and J. P. Schadé, Amsterdam, Elsevier. 1960, pp. 104-115.[19]



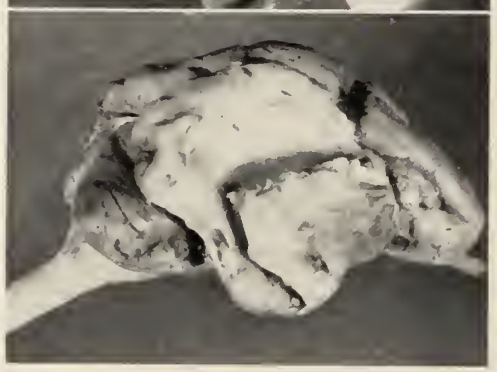


Fig. 5. *(above)*. Monkey No. 4711. A posterior view of the fourth ventricle and brain stem is shown with pointer indicating the incision site in the left superior cerebellar peduncle.

(Reprinted from *Journal of Neurosurgery*.[21])

Fig. 6. *(below)*. Monkey No. 4711. Right lateral view of brain showing residual right cortical and subcortical tissue.

(Reprinted from *Journal of Neurosurgery*.[21])

tongue making deglutition difficult and confining speech to monosyllabic answers. His I.Q. was reported to be fifty-one (Fig. 7).

On November 18, 1958, a right suboccipital craniotomy was performed with excision of both cerebellar tonsils, the nodule, the uvula, the lingula, the pyramis, and the posterior medial third of the right cerebellar hemisphere. Improvement was very gradual postoperatively. Five months later, he was able to smile, had less head movement, loss of severe spasms in the lower extremities, and better control of his left arm. His coordination was improved in that he was able to drink a glass of milk (Fig. 8) and haltingly, slowly feed himself with self-aid appliances. His lower extremities were hypotonic and he could now voluntarily flex his lower extremities at the knee with only slight spasm. Three years postoperatively, involuntary head movement was less prominent and coordination had definitely further improved. After a prolonged period, he could pound out words on the typewriter using one finger. At this time his extremities had become almost too hypotonic so that now there was almost insufficient tonus to support him (Fig. 9).*

Comment.—In this case, the boy's neurological deficit was probably due to a primary lesion in the region of the caudate nucleus and basal ganglia. The deliberate insertion of a secondary lesion in a selected site in the cerebellar hemisphere and vermis altered the balance of these areas so that a more nearly normal tonus and movement could be achieved. It was thought that if this type of operative procedure could be properly worked out changes in tonus and movement could be influenced by one operation on the cerebellum

*The symptoms have since recurred, and the patient has had a cryogenic thalanotomy with marked improvement.



Fig. 7. Case 2. Photograph of child with extensive cerebral involvement due to erythroblastosis. He showed tremendous hypertonicity and choreoathetoid movements.

(Reprinted from *Journal of Neurosurgery*.[21])



Fig. 8. Case 2. The patient could now haltingly raise a glass of milk to his mouth and drink from it. This was facilitated to some degree by the loss of the severe extensor spasm of the legs as well as the diminished tone in the arms.

(Reprinted from *Journal of Neurosurgery*.[21])



Fig. 9. Case 2. A year and a half postoperatively, there was hypotonia in all four extremities which was more noticeable in the lower than the upper extremities.

(Reprinted from *Journal of Neurosurgery*.[21])

instead of two operations in the subcortical areas of the cerebral hemispheres in which instance there would be greater danger of paralysis and disturbance of intellect.

the cerebral hemispheres with hemiplegia. McKenzie[13] was given credit for having performed hemispherectomy for convulsive seizures in 1938, but Krynauw[12] provided the procedure with the necessary impetus for

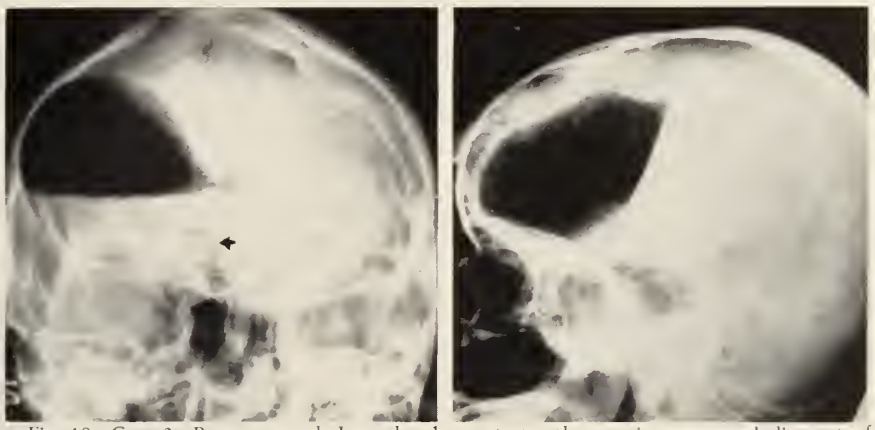


Fig. 10. Case 3. Pneumoencephalography demonstrates the massive porencephalic cyst of the right lateral ventricle on the anterior and right lateral views. The characteristic shift of the third ventricle toward the side of the atrophic hemisphere is well shown *(arrow)*.

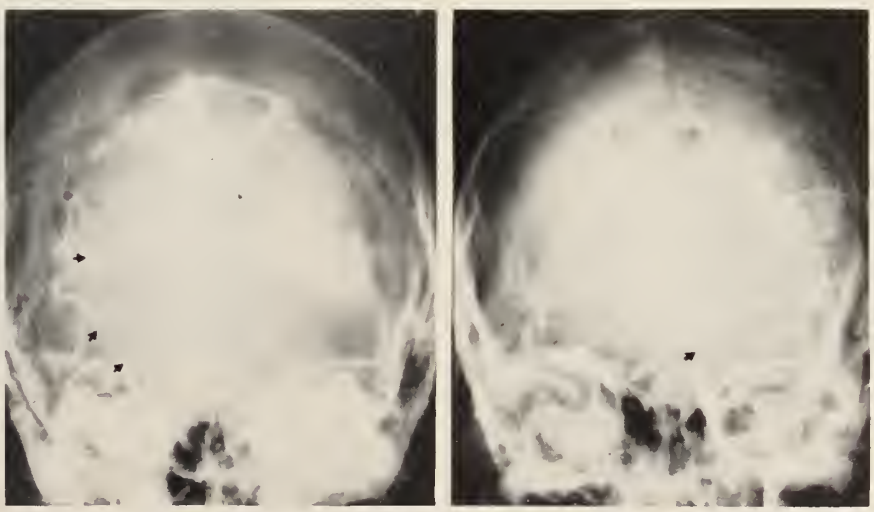


Fig. 11. Case 3. *(left)* The right internal carotid arteriogram demonstrates aplasia of the right middle cerebral artery *(arrows)*. Both anterior cerebral arteries were filled by this injection. *(right)* The left internal carotid arteriogram shows only filling of the left middle cerebral artery but none of the left anterior cerebral artery.

It should be very clearly emphasized that this case demonstrated considerable improvement in the patient although the authors realize that it was far from an excellent result.

Hemispherectomy for Relief of Convulsive Seizures in the Infantile Hemiplegia Patient

Dandy[8] first performed unilateral cerebral hemispherectomy in 1928 in an attempt to cure gliomas of

further clinical use in a report in 1950. Since that time there have been other discussions of this procedure among which the presentation of French et al[9] was most informative. The following case report stresses some of the interesting features of the problem.

Case 3.—L.L., a 15-year-old girl, was born following a prolonged labor. At nine months of age a diagnosis of cerebral palsy was made; when eight years old she had had her

first clonic convulsive seizure involving the left arm and hand. These attacks gradually became more severe involving the entire left side of the body with occasional episodes of déjà vu phenomena and macropsia. In spite of all types of anti-convulsive medications, seizure control could not be attained.

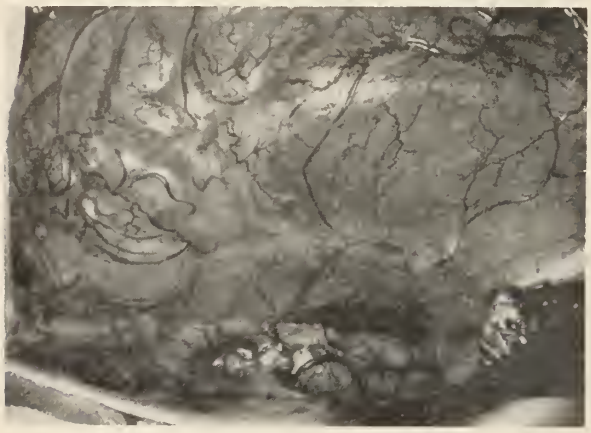


Fig. 12. Case 3. The exposed right cerebral hemisphere shows the porencephalic cyst with its thin wall overlying the right lateral ventricle in the distribution of the right middle cerebral artery.

Dr. Francis Martin examined her and upon performing a pneumoencephalogram found marked cerebral hemiatrophy and dilatation of the entire right lateral ventricle (Fig. 10). He very kindly referred her for right hemispherectomy for relief of intractable convulsive seizures.

On November 20, 1960, the patient was admitted to University Hospital. In addition to the above noted symptoms and signs she was found to be quite childish with irrepressible outbursts of laughter, an unusually keen interest in the opposite sex, and a bizarre behavior pattern. An electroencephalogram showed marked delta waves throughout the entire right hemisphere. A bilateral carotid arteriogram revealed a hypoplastic or thrombosed right middle cerebral artery. Both anterior cerebral arteries filled from the right side and neither vessel could be demonstrated by the left internal carotid artery injection, which was the side of the non-impaired hemisphere (Fig. 11). This pattern of trifurcation of the right internal carotid artery implied possible embryologic deficiency in the posterior cerebral artery circulation of the contralateral hemisphere. It is suggested that an artificial increase in the blood pressure by vasopressor agents during the operation might be desirable to promote better oxygenation of the brain through improved collateral vascular supply.

On November 30, 1960, a right frontotemporoparietal craniotomy was performed. A markedly impaired right cerebral hemisphere was found with a large porencephalic lesion predominantly in the distribution of the right middle cerebral artery (Fig. 12). On electrocorticographic recordings, it was found that an abnormal pattern was present in the right hemisphere. Almost total right hemispherectomy was performed with a deliberate attempt to spare the right anterior cerebral artery throughout its course inasmuch as part of the collateral blood to the undiseased left hemisphere was provided through this channel. During the procedure, vasopressor agents were used as suggested above. Postoperatively, the patient did well for approximately twelve hours. She rather suddenly developed diminished respirations and dilated fixed pupils which were witnessed by Dr. Bud DeJonge, and the patient was then returned rapidly to the operating room for re-exploration. Approximately six hundred cubic centimeters of blood was found in the dead space left by the cerebral hemispherectomy. It was evacuated and the tentorium sectioned to permit better circulation of the cerebrospinal fluid and any residual blood. The wound was closed and the patient made an uneventful recovery.

Two years later, she was seizure-free, had less spasm in her impaired left extremity, had improvement in her general mental development and behavior and was doing very well in school. Her mother and teachers have expressed amazement at this very satisfactory result (Fig. 13).



Fig. 13. Case 3. Patient shown one year postoperatively. Note the left infantile hemiplegia with atrophy.

Comment.—The opportunities presented by hemispherectomy in relieving intractable seizures and some degree of spasticity in infantile hemiplegia are demonstrated. There is nothing more gratifying than rehabilitating such a young patient by returning her to society and reinstating her in school, particularly at a time when she was about to be institutionalized because of her intractable convulsive seizures. The importance of the proper demonstration of the cerebrovascular supply to the diseased and to the unimpaired hemispheres is shown; this prevented a tragedy through careful preservation of the blood supply via the right anterior cerebral artery.

Inaccuracy of Hallucinations as a Localizing Symptom in Temporal Lobe Lesions

For many years, Penfield and his associates[16,17,18] have studied the temporal lobe in patients treated surgically for temporal lobe seizures. They ascribed the presence of olfactory, auditory, and formed visual hallucinations, together with macropsia, micropsia, déjà vu phenomena and feelings of unreality as symptoms of *temporal* lobe involvement. For some time, the authors had been certain that patients, who had complained of the various types of hallucinations noted above, were afflicted with *frontal* lobe lesions.

The following case, and numerous subsequent observations, have done much to cause a reappraisal of the concept that hallucinations are of great value in the localization of cerebral lesions.[20]

*Case 4.**—A 30-year-old patient, D.S., was admitted to the hospital on June 15, 1959, because of headache. Five weeks prior to admission the patient had struck her left mastoid region on some furniture and a week later had some bifrontal and occipital headaches. There had been no loss of consciousness but nearly daily nausea, vomiting, and stiff neck. For three weeks prior to hospitalization, the patient noted formed visual hallucinations in the right homonymous field, which consisted of headless persons with bizarrely shaped arms attached to their necks. She also saw colored butterflies, circles, and bars. In addition, she had auditory hallucinations, hearing whistling noises like the sound of wind. Simultaneously, there were olfactory hallucinations best described as being similar to the odor of foul cigar smoke. Five or six days before admission to the hospital, she had had numbness and tingling in the fingers of the right hand with a swollen sensation in the digits.

At three years of age, she had had an attack of meningitis which had left her with a residual partial amblyopia. In 1954, the patient was involved in an automobile accident sustaining an injury to the left eye requiring its enucleation. She had a left orbital prosthesis and central vision in the right eye was partially obscured due to chorioretinitis and high myopia; otherwise, the patient was neurologically negative.

Skull and chest x-rays were negative and lumbar puncture studies were normal. The electroencephalogram demonstrated an abnormal pattern with high voltage delta waves bilaterally in the prefrontal, left anterior temporal and, to a lesser degree, the left midtemporal regions, suggesting a left frontotemporal focal lesion. On left internal carotid arteriography, there was a suggestion of a left frontotemporal lesion. A ventriculogram showed a mass inferior to the anterior portion of the lateral ventricles and a shift of the ventricular system to the right side. There was good filling of the left temporal horn, but a posterior displacement of the left anterior frontal horn of the lateral ventricles suggested a left frontal space occupying lesion.

On June 23, 1959, a left frontotemporal craniotomy was performed under local 2 per cent xylocaine anesthesia

*Condensed and reprinted from *Neurology*, 11, No. 2: 172-79, 1961.[20]

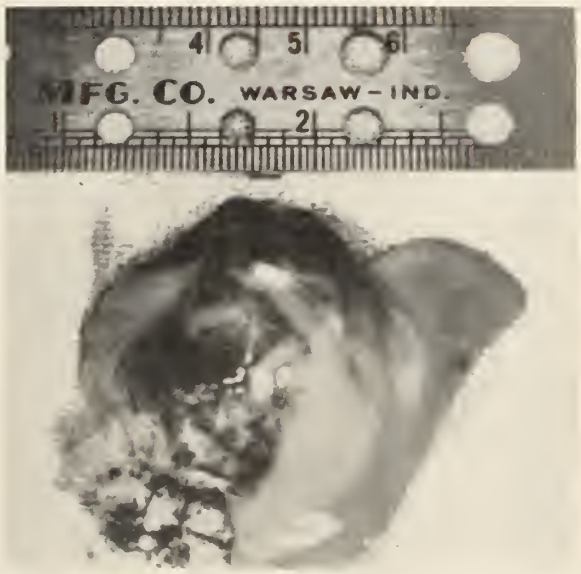


Fig. 14. Case 4. Specimen consisted of thickly encapsulated brain abscess about 2.5 cm. in diameter which has been sectioned medially in a plane parallel to the ruler permitting escape of thick green pus. The posterior wall of abscess is shown where the abscess had been stripped from its bed in the tip of left frontal lobe.

(Courtesy *Neurology*, 11: No. 2 (Feb. 1961. Copyright 1961 by Lancet Publications, Inc., Minneapolis.)

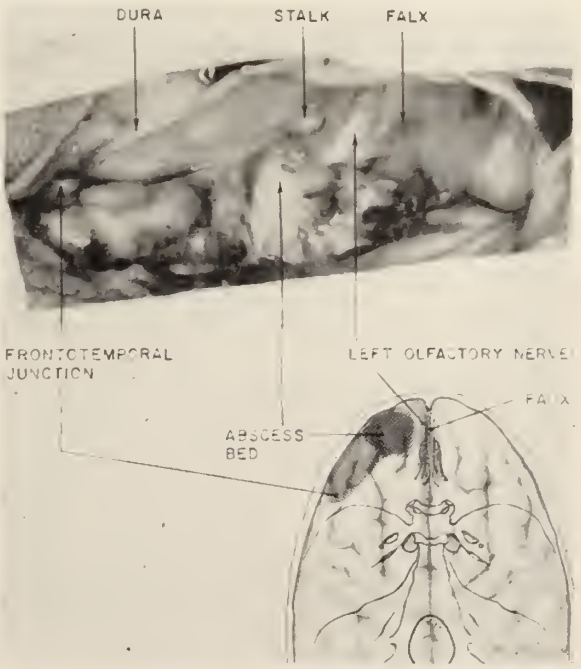


Fig. 15. Case 4. A picture of operative field exhibits brain abscess bed bounded by abscess stalk communicating transdurally with left orbit frontally, left olfactory nerve medially, and normal brain laterally toward left frontotemporal junction. Drawing at bottom shows location of operative field.

(Courtesy *Neurology*, 11: No. 2 (Feb. 1961. Copyright 1961 by Lancet Publications, Inc., Minneapolis.)

supplemented by intravenous demerol, compazine and surital. The dura was opened exposing the left frontal and temporal lobes; the brain was not under increased pressure. Electrocorticography was carried out. No spikes were found, but slow waves were noted. Electrical stimulation of the left temporal cortex was performed but it was impossible to reproduce the hallucinations. Unfortunately, the left frontal lobe was not stimulated because the patient became too uncooperative. Depth or subcortical electrodes were inserted. Recording from the anterior mid-frontal gyrus, there was no record whereas in the superior temporal area there were slow waves. In the superior frontal area, the pattern was normal. At the tip of the left frontal lobe, a firmly encapsulated mass 2.5 centimeters in diameter was encountered. It was completely excised with its capsule intact and, upon sectioning it, green pus exuded under pressure (Fig. 14). Further investigation revealed a tract extending from the osteomyelitic roof of the left orbit to the tip of the left frontal lobe (Fig. 15). This was excised, a fascial graft applied for solid dural closure, and the wound closed.

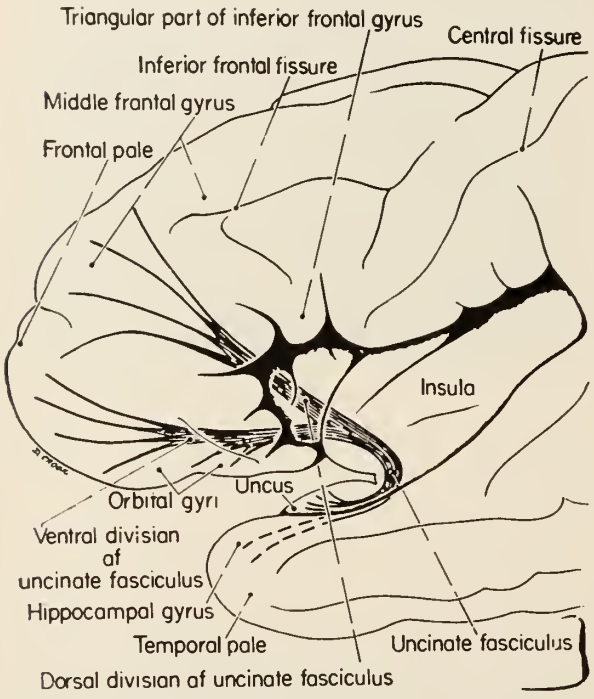


Fig. 16. Diagram illustrates uncinate or frontotemporal association bundle. It has both a superior and inferior branch. (Courtesy Crosby, E. C., Humphrey, T., and Lauer, E. W.: Correlative Anatomy of the Nervous System. New York: The Macmillan Company, 1962.)

Immediately postoperatively, the patient's hallucinations disappeared. Unfortunately the patient subsequently developed a wound infection and osteomyelitis requiring excision of the bone flap. Upon rechecking the patient seven months postoperatively, she was found to be neurologically negative except for her preoperative ophthalmoplegia. Her electroencephalographic recording showed a regression of the abnormal waves in the left temporal area following excision of the left frontal lesion. A pneumoencephalogram exhibited relocation of the ventricular system and excluded any left temporal lobe lesion. Cranioplasty was performed to fill in the operative defect. Three years postoperatively, she remained seizure free and neurologically was unchanged.

Comment.—The uncinate fasiculus interconnects the frontal and temporal lobes (Fig. 15). It splits into two portions.[6,7,11] The more ventral part of the bundle interrelates the hypocampal gyrus and amygdula with the orbital gyri and the more dorsal portion interconnects the frontal part of the mid-frontal gyrus with the temporal cortex.[22] From the frontal region, impulses are carried through the fibers of the inferior fronto-occipital fasciculus to the mid-temporal region and occipital area (Fig. 16). The relationship of the abscess to the uncinate fasciculus is apparent. Any irritation of this fiber pathway in the frontal area may cause a discharge into the temporal region with the triggering off of temporal lobe symptoms. Conversely some of the cases with temporal lobe lesions may present frontal lobe symptoms.

The patient has had a most gratifying recovery since she remains asymptomatic with the exception of her previous visual loss. She is seizure-free.

This case, in addition to five others, is to be reported in London in June, 1963.[23]

Summary

A group of cases has been presented, treatment of which, by team effort, has not only benefited the patient but has expanded in a measure our knowledge of certain aspects of diagnosis and treatment of disease of the central nervous system.

The individual neurological surgeon is unable ordinarily to cope with all of these problems because of the lack of time and facilities. This type of work is time consuming and must be confined to a larger medical center.

Finally, there is almost inevitable specialization within the field of Neurosurgery. This is now occurring rather rapidly and will continue if there is to be proper patient care and yet further scientific progress in the neurological sciences.

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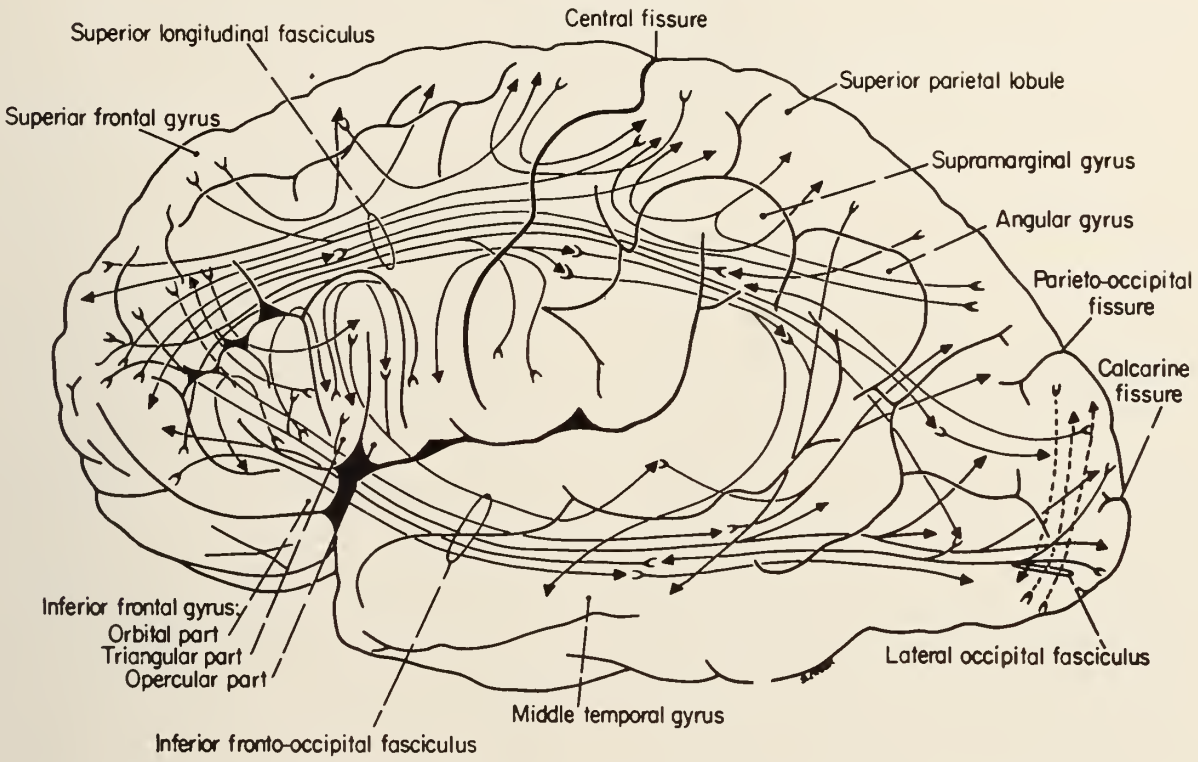


Fig. 17. Diagram demonstrates region of inferior frontal gyrus, where fibers of uncinate fasciculus intermingle with those of inferior fronto-occipital fasciculus discharging to middle temporal regions and visual centers in occipital area. (Courtesy Crosby, E. C., Humphrey, T., and Lauer, E. W.: Correlative Anatomy of the Nervous System. New York: The Macmillan Company, 1962.)

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(Additional references on Page 204)

Modern Concepts of the Treatment Of Cleft Lip and Cleft Palate

Reed O. Dingman, M.D., F.A.C.S.
Ann Arbor, Michigan

THE BIRTH of a child with a cleft lip and cleft palate deformity initiates a chain of events of great significance to the patient, his family, the medical profession and to the community. To the family expecting a normal, healthy child, the immediate reaction to the birth defect is one of disappointment, anxiety and frustration. The parents are helpless and at a loss for knowledge of ways to meet this depressing situation. It is the obligation of the physician delivering the baby to reassure and bolster the morale of the family and to initiate a proper program of management. The appearance of congenital facial deformities is not the catastrophic event it was considered to be a few years ago. The plastic surgeon, constantly faced with the problem of congenital deformities, in most instances is able to restore form and function to the extent that these unfortunate children are able to adequately adjust in a competitive society. A high percentage of the deformities may be reasonably well corrected but the problem of treatment imposes an emotional and economic crisis upon the family to which adjustments may be slow and difficult.

Assessment of the responsibility for the deformity of the child by the parents upon one or the other, guilt complexes, emotional problems initiated by the cosmetic and speech defects and social and financial problems may result in frigidity and a further childless marriage or divorce. Most of these difficulties can be minimized or averted by careful explanation and reassurance by the family physician, surgeon or the trained social worker. An excellent 16 mm. 28 minute colored moving picture film on the care of the cleft palate child produced by the Audio-Visual Education Center of the University of Michigan is available to physicians for viewing by parents. This practical film covers most aspects of treatment and is helpful in counseling parents for the events ahead.



The Author
REED O. DINGMAN, M.D.

In Michigan, care is available through the facilities of the Michigan Crippled Children's Commission for all patients with congenital defects whose families are unable to finance treatment on a private basis. The care of a high percentage of cleft lip and palate defects is financed by insurance or private funds.

The treatment of the cleft lip and cleft palate child is a continuing process including the services of the plastic surgeon, pediatrician, otolaryngologist, specialists in various phases of dental care, speech therapists and social workers. The span of treatment most often can be considered to extend through the years of growth and development and into adult life.

Cleft lip and cleft palate is the second most frequent congenital defect according to birth records studied in Wisconsin,[1] Pennsylvania[2] and Michigan. In Michigan, the incidence is 1:740 live births.[3] Cleft lip and cleft palate is among the commonest congenital deformities with an estimated 200 children born with this defect in the State of Michigan each year. Club foot is the most frequent congenital anomaly followed by oral clefts, spina bifida, polydactylism, hypospadias, hydrocephalous and congenital heart disease. Ivy[4] reports from the State of Pennsylvania that 11 per cent of all cases of cleft lip and cleft palate have associated congenital anomalies.

The deformity can be conveniently classified into three main groups: cleft lip alone, cleft lip and cleft palate, and cleft palate alone. In the category of cleft lip alone, the ratio is two males to one female; in the cleft lip and cleft palate group, the ratio is approximately two males to one female; in the group with cleft palate alone, the ratio is approximately three males to four females.

Research is being conducted in various centers to determine the etiological factors which result in the

From the Department of Surgery, University of Michigan Hospital, and Department of Plastic Surgery, St. Joseph Mercy Hospital, Ann Arbor, Michigan.

development of cleft lip and cleft palate deformities. Several theories have been advanced but none yet has been universally accepted and recent research seems to support the theory that hereditary factors plus stress phenomena during the early weeks of pregnancy are responsible for these birth anomalies. Until the etiological factors can be more definitely determined and preventive measures instituted, the surgeon must continue to correct deformities as they occur and try to improve the surgical management to obtain the maximum habilitation for these individuals.

Federal, State, private and foundation funds are now being made available for research in the field of congenital anomalies. Significant advances have been made in this direction. Perhaps the time will come when prevention will eliminate our problems in this regard.

Improvement in the management of the cleft lip and cleft palate patient has come about during the past decade by the establishment of groups of specialists interested in various phases of the cleft palate problem. In a large measure, this can be attributed to the efforts of Dr. Herbert K. Cooper, a specialist in orthodontia and Professor of Cleft Palate Therapy in the School of Dentistry, University of Pennsylvania. Doctor Cooper fathered the Lancaster Cleft Palate Clinic, Inc., in 1939 on the basis of financial support obtained through the Lancaster Rotary Club.[5] This Clinic was the first to provide service to cleft palate patients through the efforts of a multi-professional team. Cleft palate clinics have been established throughout the world based on Doctor Cooper's original concept.

In Michigan, cleft palate clinics are in operation at Children's Hospital, Detroit; Mary Free Bed Hospital, Grand Rapids, Michigan; St. Joseph Mercy Hospital, Ann Arbor; Sinai, in Detroit and University of Michigan Hospital; Saginaw General Hospital, Saginaw, Michigan.

Although not members of a formal cleft palate clinic, many plastic surgeons working closely with other medical specialists, dentists and speech therapists are able to obtain comparable or better results than those obtained through a formal organized cleft palate clinic. Some observers in this field are of the opinion that cleft palate clinics are redundant and that better results can be obtained when the program of rehabilitation for the child is directed by the surgeon in cooperation with interested medical and paramedical personnel. Certainly in the early phases of treatment the problem requires the efforts of the family physician, the pediatrician and the plastic surgeon. Following surgical correction of the lip and palate deformity, the patient should have the value of consultation with other disciplines interested as indicated.

It is important to understand that changes incident to the growth and development of the child result in a continuously changing picture of the total deformity and its associated problems. These changes make it highly desirable that the patient's total picture be evaluated on a yearly basis. Changes incident to the loss of deciduous teeth and the eruption of the permanent teeth, growth of the jaws and facial structures, the continuing influence of scar contracture, changes due to endocrine factors and the development of social, emotional and psychologic problems must receive ever constant attention and consideration.

The number of children with cleft lip and cleft palate is far greater than those with other conditions which receive greater publicity and financial support. The patient with a cleft lip and cleft palate deformity although not on crutches or in a wheelchair in most instances must be considered a crippled child. The telltale marks of surgery, speech defects and dental inefficiency may remain in spite of the good care by present methods. Poor appearance and impaired speech may result in social and economic problems which precipitate psychologic crises. Unemployability and social maladjustment are the net results unless better care is made available. Many cleft patients are getting substandard care under our present system.

Would it not be wise to use more public funds for the management of needy cleft lip and cleft palate patients to make them acceptable from the standpoint of appearance and speech and thereby make them more useful citizens? The money invested would be returned many times over by making these patients employable self supporting tax contributors instead of unemployed individuals who are a drain upon State finances.

Cleft Lip Repair

It is possible with modern surgical techniques to obtain good esthetic and functional results in the correction of cleft lip and cleft palate deformity. One of the greatest challenges in plastic surgery is the correction of double cleft lip and cleft palate but technical advances are resulting in ever-increasing improvement in the final results.[6]

It is common practice among surgeons to correct the clept lip deformity as soon as the patient has regained its birth weight, is established on an adequate feeding schedule and is considered by the pediatrician to be a good surgical risk. This generally is at ten to fourteen days of age. There is no advantage in operation in the

first two or three days of life and, if necessary, operation may be delayed several weeks or even months without jeopardizing the result. It is preferable to complete the lip repair before the child leaves the hospital. This permits the family to exhibit a normal looking child to their friends and relatives and eliminates much of the anxiety, curiosity and gossip stimulated by the presence of an unoperated cleft deformity in the home.



Fig. 1. Infant born with complete unilateral cleft lip and cleft palate. Repaired in a single stage operative procedure at ten days utilizing the triangular flap method of repair. This operation results in a full, pleasing lip with adequate vermilion tissue and a good cupid's bow, a normal appearing nose and minimal scar in the line of repair.

Single cleft lip repair generally can be accomplished in one operative procedure. Double cleft, in most cases, is now repaired in a two-stage procedure. One side of the cleft is repaired at ten to fourteen days of age and the opposite side two or three weeks later.

Great improvement in the results of clept lip surgery have followed the reintroduction of the quadrilateral flap method of Hagedorn by LeMesurier.[7] Other improvements by Steffensen,[8] Tennison,[9] Millard,[10] and Randall[11] followed rapidly. All are modifications of the z-plastic principle which results in an offset line of closure with maximum conservation of vermilion border tissues. The recognition by Marcks[12] that the cupid's bow is present in all cleft lips has resulted in pleasing satisfactory results in even the most severe single cleft lip deformity (Fig. 1).

Cleft Palate Repair

Cleft of the palate can be corrected surgically in most all cases. There are a few instances of very wide cleft in which it seems judicious to utilize dental appliances rather than attempt surgical closure which might result in failure due to inadequacy of tissues.

The type of operative procedure for cleft palate closure is individually determined by the extent of the cleft and the tissues available for repair. At the University of Michigan, we favor the two-stage operative procedure for closure of the complete cleft palate. The first stage of the operation is carried out at 18 to 20 months of age and is designed to close the anterior portion of the cleft. Three or four months later the posterior portion of the cleft palate is lengthened and closed by a "setback operation."

In some cases, only the posterior palate is closed at the primary operation leaving the anterior portion of the palate open to be closed a year or two later. The anterior palate defect will narrow considerably after closure of the soft palate making the final operation upon the anterior region less difficult.

The incomplete cleft palate is closed in a single operative procedure usually by the Brown[13] setback operation. The time of operation varies from 18 to 24 months.

The lip and palate deformity should be completely corrected before the child starts to school. Some surgeons favor palatal closure at six to eight years of age. Although it is certain that some collapse of the maxillary arch may occur as a result of scar contracture in the palate due to early traumatic surgery, it seems inadvisable to delay surgical closure of the palate until after school age in order to avoid minor degrees of malocclusion. Usually the malocclusion can be overcome by orthodontic means.

Bone Grafts for Cleft Palate Repair

A new concept in management of the alveolar ridge cleft was introduced by Johanson of Gothenberg, Sweden,[14] and Schuchardt of Hamburg, Germany.[15] Both of these investigators have done extensive work in the use of autogenous, iliac and tibial bone grafts to span the cleft of the alveolar ridge and anterior palatal area. Most investigators using bone grafts close the lip primarily at two or three weeks of age and at

six months to two years of age close the gap across the alveolar cleft by means of soft tissue flaps and at the same time insert bone grafts. There seems to be evidence that the bone grafts prevent collapse of the maxillary arch and provide a skeleton for alveolar bone development which aids in the eruption of the permanent teeth. Sufficient data is not yet available for evaluation of the effectiveness of these procedures but it seems that this may be a "break through" in cleft palate management.

Follow-Up Program

After surgical closure of the lip and palate, it is important that the patient be followed and reevaluated on a yearly basis. It is at this stage that a well directed program of evaluation by various interested specialists should be carried out.

The child should be started on a dental program which, at the beginning, may consist simply of periodic visits to the dentist for cleaning of the teeth and filling of small cavities. The treatment of carious teeth and malalignment of teeth may later require the services of a pedodontist and an orthodontist. Prosthetic appliances are necessary in some cases where the cleft is unusually wide and cannot be operated upon or where surgical failure results in poor speech performance.

At three to four years of age, speech evaluation can be carried out with some degree of success. Obvious speech defects call for therapy which usually can be carried out in the patient's home area by trained speech therapists located in public schools and in various centers throughout the State. Suggestions to the family by the speech therapist are helpful in providing continuing speech therapy from day to day in the home.

A cleft-palate child should be under the frequent observation of the family physician or pediatrician and especially watched for development of middle ear infection. Before the widespread use of antibiotics, approximately one-third of all cleft patients had marked impairment of hearing. Under present good medical management, the incidence of hearing defects in the cleft child has diminished considerably. Infection that does not respond to the usual conservative care should come to the attention of the otolaryngologist. Tonsillectomy and adenoidectomy, if done, should be carried out with the greatest degree of care in order to avoid formation of scar in the area of the palate and pharynx. The presence of normal adenoid tissue does help in velopharyngeal valving and overenthusiastic removal of adenoid tissue may be detrimental to the patient's speech. Careful removal of the infected adenoid tissue about the eustachian tubes many times can be done by simple lateral adenoidectomy leaving the central mass of adenoid tissue to aid in velopharyngeal closure. Chronically infected tonsils should be removed and usually with care the scar contracture is minimal and does not interfere with speech results.



Fig. 2. Repair of the bilateral cleft lip in infancy results in a broad, flat, short nasal tip due to congenital absence of the columella. Columella raise operation is done at the age of five or six years to improve appearance, give a more normal character to the nasal tip and to release tension on the anterior portion of the nasal septum.

Additional surgery generally is unnecessary during the remainder of the childhood years except for the double cleft lip patient. In double cleft lips, there is usually marked flattening of the tip of the nose due to a short columella. Surgery at five or six years of age to lengthen the columella improves the appearance and eliminates tension at the nasal tip. Uncorrected prolonged tension may interfere with septal development and result in deformity and obstruction (Fig. 2).

Late Surgical Problems

With the appearance of secondary sex characteristics, late developing deformities in the cleft patient may require surgical procedures that were not obvious or considered necessary before the child reached adolescence. A teen-age cleft lip and palate individual is often "the forgotten patient." As a result of adolescent problems, many patients are poorly adjusted socially and psychologically and exhibit psychic scars from repeated mental trauma and anxiety. He may have been discharged as a completed case following surgery during childhood at which time the results appeared to be excellent. Growth and developmental

changes, however, accentuate the minor residual deformities existing following childhood surgery and create new problems. The upper lip may be short and tight and the speech may be poor. Deformity is especially noticeable in the nasal structures. The nasal tip may become bulbous and the hanging columella and depressed ala become more conspicious with the growth and development of the child nose to the adult nose. This is associated with accentuated deformity of the nasal septum resulting in airway obstruction.

In spite of adequate orthodontic treatment, usually initiated at the age of eleven or twelve, there may be underdevelopment of the maxilla and the middle third of the face. The occlusion of the teeth can be adjusted by orthodontic means or prosthetic appliances but due to underdevelopment and deformity of the middle third of the face, the lower jaw may appear to be overdeveloped or prognathic. The occlusion between the upper and lower teeth may in some cases be improved by surgical means to correct the discrepancy between the size of the maxillary and mandibular arches.

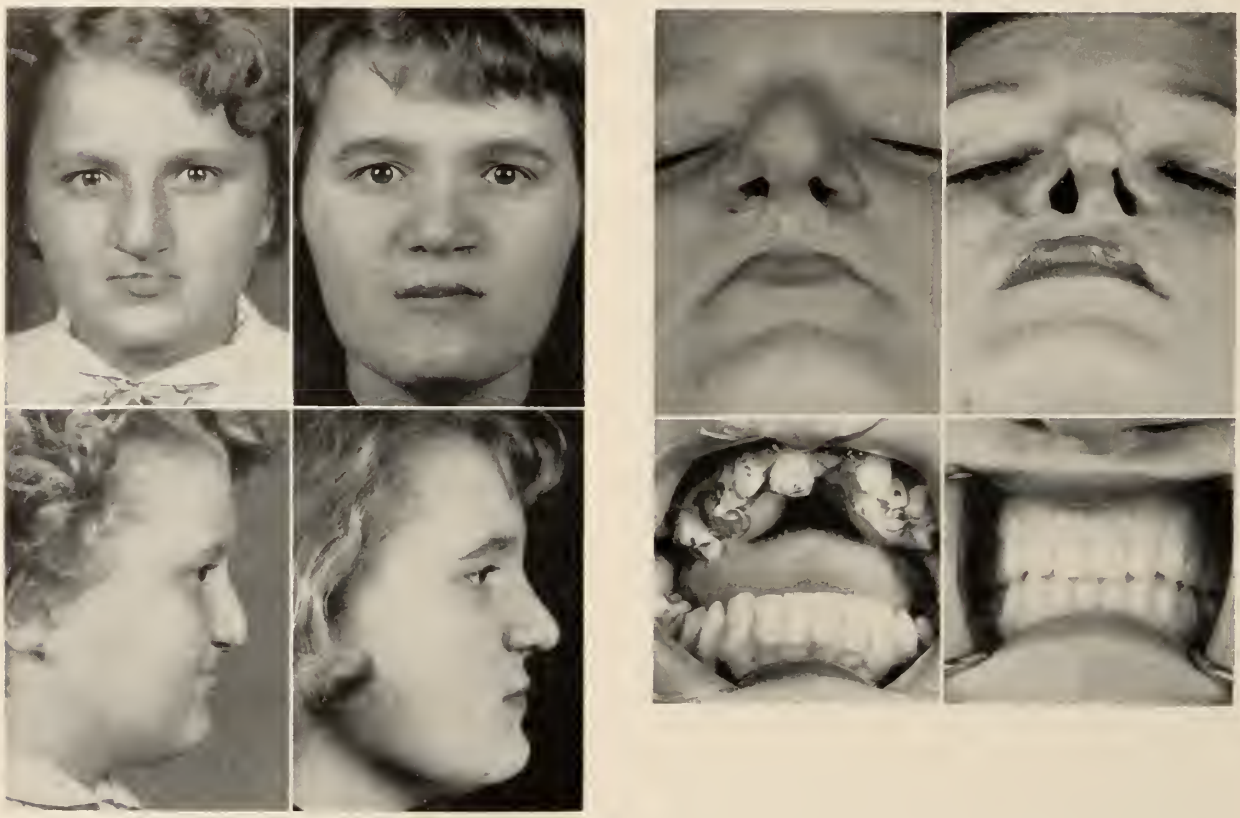


Fig. 3. This patient was operated upon for bilateral cleft lip and cleft palate in infancy. Her teenage deformity consisted of a short scarred, inadequate upper lip, nasal deformity, deviation of the nasal septum, underdevelopment of the maxilla, irregularity and deformity of the teeth and a short palate with poor speech. Rehabilitation was effected by careful execution of a series of well planned, coordinated operative procedures consisting of reconstruction of the upper lip by use of a full thickness pedicle flap from the lower lip, rhinoplasty, submucous resection and palatoplasty with pharyngeal flap operation. Construction of a full upper denture to fit over her remaining natural upper teeth and deformed palate improved dental function, speech and appearance. This attractive young lady is now employed as a private secretary.

Late Surgical Rehabilitation

A well-planned program of surgery, dental rehabilitation, speech therapy and counseling will often salvage "the forgotten patient" (Fig. 3). The plastic surgeon can do much for these patients by evaluation of the problem and outlining a series of procedures for correction of the defects. The surgical plan should be carefully explained to the parents and carried out on a predetermined schedule (Fig. 4).

Deformities of the lip, nasal septum and nasal bony structures often can be corrected by a single operative procedure. Although extensive, the operation is warranted on the basis that these defects are interdependent and more effectively corrected simultaneously. Excision of scar from the upper lip, submucous resection of the nasal septum and transfer of a full thickness



Fig. 4. This unhappy, unemployed 21-year-old man was treated in infancy for a bilateral cleft lip and cleft palate deformity. His speech and appearance were poor and he was socially maladjusted. Surgical rehabilitation consisted of a columella raise, supplementing missing tissue in the upper lip by use of a flap from the lower lip, rhinoplasty, submucous resection, and construction of an upper denture. This man has been socially, mentally and economically rehabilitated.

vermilion border flap from the lower lip to the upper lip can be carried out in one operative procedure. At subsequent stages, the pedicle flap from the lower to the upper lip is cut, the flap is adjusted and within a few months final corrective procedures can be carried out. Rhinoplasty to correct residual nasal deformity will give the patient improved facial contour (Fig. 5).

Patients with a protruding lower jaw have an unpleasant appearance. Correction can be done by osteectomy of the lower jaw to bring the mandibular

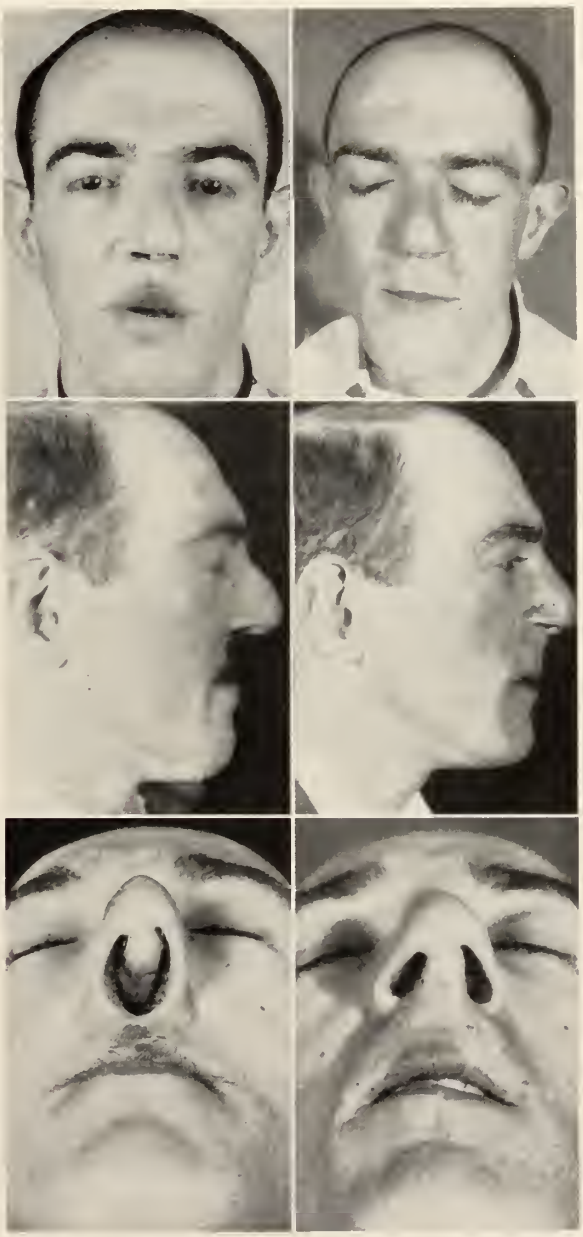


Fig. 5. Treatment in infancy for bilateral cleft lip and cleft palate consisted of excision of the premaxilla and direct closure of the lateral lip segments. This resulted in a tight, short, narrow lip, absence of the columella and deformity of the palate. The patient was a part time dishwasher being unable to obtain any other type of employment. His speech was unintelligible and his appearance was grotesque. Socially he was unacceptable. He was emotionally disturbed and unable to compete for the usual types of employment. Surgical rehabilitation was accomplished by reconstruction of the upper lip and columella with a flap from the lower to the upper lip. Surgical correction of the palate was effective in closing the defect. An upper denture with a pharyngeal bulb gave support to his upper lip, supplied adequate teeth for mastication and resulted in excellent speech. Since rehabilitation the patient has been steadily gainfully employed and has adjusted socially and psychologically.

teeth into a more favorable relationship with the maxillary teeth. Mandibular discrepancies are sometimes relative and appear to be severe because of underdevelopment of the maxillary structures. The mandible can be shortened to provide optimum occlusion and in some cases additional improvement is possible by use of prosthetic appliances or orthodontic adjustment of the maxillary teeth.

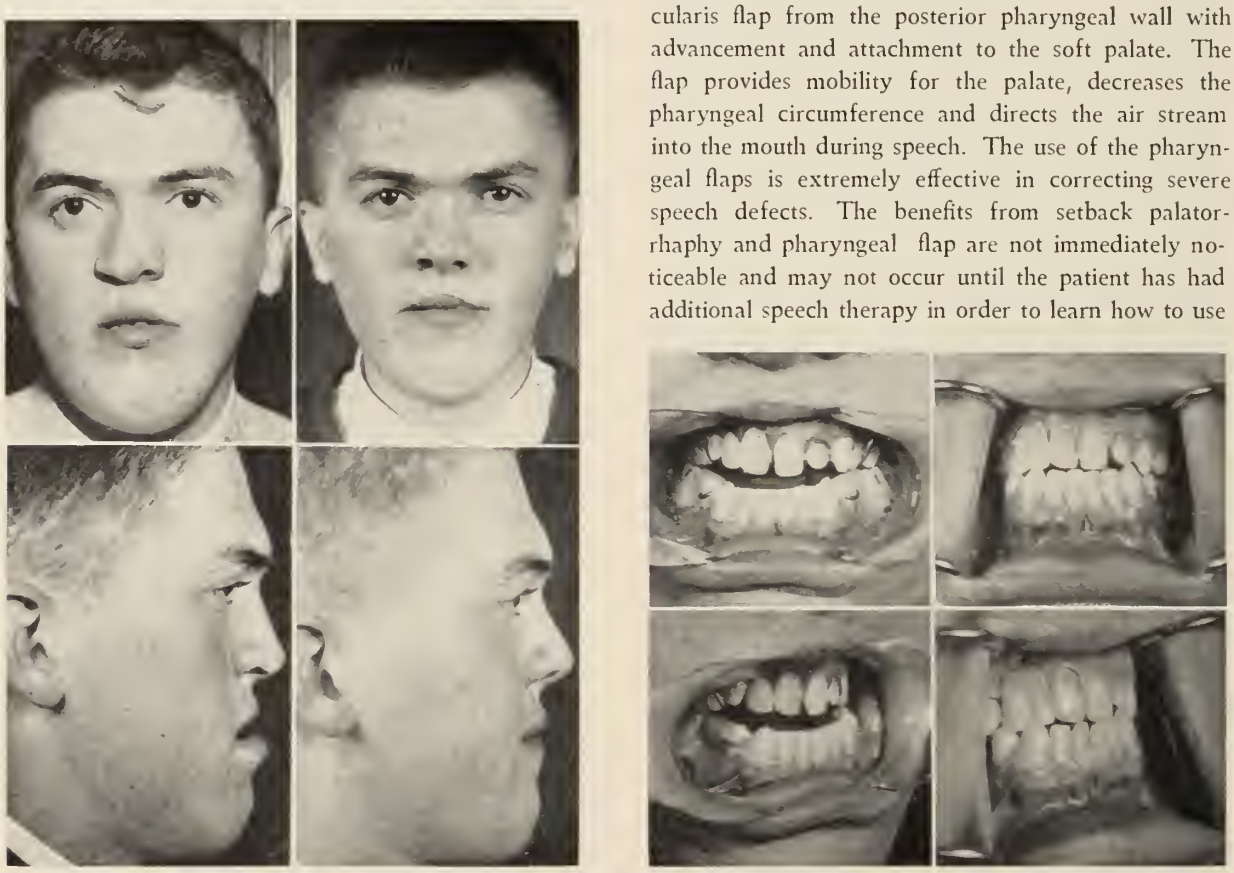


Fig. 6. This 20-year-old college student was treated in infancy for a unilateral complete cleft lip and cleft palate. His deformities consisted of a tight, scarred upper lip, a prominent protrusive lower jaw, deformity of the nose, malocclusion of the teeth, a scarred tight palate with poor speech. Eight years of speech therapy had been ineffective in producing acceptable speech. The plan of reconstruction included shortening of the mandible by osteectomy, revision of scar of the upper lip, rhinoplasty, submucous resection, lengthening of the palate and pharyngeal flap operation. The surgical procedures resulted in complete rehabilitation from the standpoint of speech, efficiency of mastication, social and psychological adjustments. He has graduated from college and is gainfully employed in business.

Secondary operations upon the palate may be indicated if the patient has nasal speech that will not respond to speech therapy. A prosthetic appliance with a pharyngeal bulb constructed by the prosthodontist to partially occlude the velopharyngeal defect is effective and often results in very good speech (Fig. 6). There are certain disadvantages to mechanical devices of this type and whenever possible it is desirable to correct the defect surgically. Surgical procedures designed to lengthen the palate and improve the velopharyngeal valve consist of the "setback operation." The "setback operation" sometimes combined with a pharyngeal flap operation, gives excellent results. The pharyngeal flap operation consists of elevation of a mucosal and muscularis flap from the posterior pharyngeal wall with advancement and attachment to the soft palate. The flap provides mobility for the palate, decreases the pharyngeal circumference and directs the air stream into the mouth during speech. The use of the pharyngeal flaps is extremely effective in correcting severe speech defects. The benefits from setback palatorrhaphy and pharyngeal flap are not immediately noticeable and may not occur until the patient has had additional speech therapy in order to learn how to use the new anatomical structures. The results have been extremely gratifying. Many patients with almost unintelligible speech have been converted to patients with socially adequate speech by the pharyngeal flap.

Summary

The modern treatment of the oral cleft patient is discussed. The advisability of a multidisciplined approach to the management of the total problem is emphasized. Care of the oral cleft cripple is a continuing process extending through infancy, childhood and into adult life. The plastic surgeon in cooperative efforts with other medical and paramedical specialists can habilitate the cleft palate patient physically, psy-

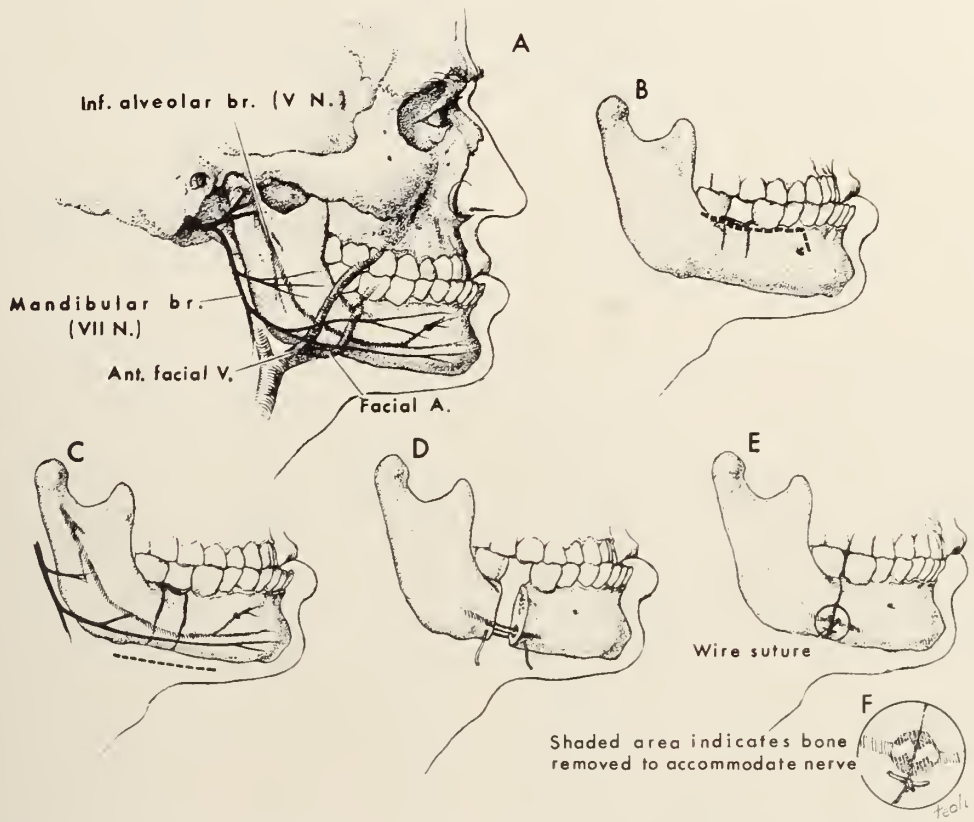


Fig. 7. This method of shortening the mandible to improve occlusal relationship was used for correction of patient shown in Figure 6. Approximately 1 cm. of bone was removed from each side from the molar region and the protruding anterior part of the mandible was set posteriorly and fixed in accurate position with the proximal segments. Intermaxillary fixation was maintained for six weeks.

chologically and socially and increase his potential as a useful, self assured, self supporting citizen.

Acknowledgment

Figures 6 and 7 are reprinted by courtesy of Williams and Wilkins Co., Baltimore, Md., from the *Journal of Plastic and Reconstructive Surgery* (Vol. 25, No. 3, March 1960) from the article, "Osteectomy of the Mandible in Cleft Lip and Cleft Palate Habilitation," Reed O. Dingman, M.D.

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221 North Ingalls
Ann Arbor, Michigan

Some Current Problems in the Surgery Of Arteriosclerosis

D. Emerick Szilagyi, M.D.
Detroit, Michigan

THE SWIFT growth of surgery of the arteries during the past decade has been one of the outstanding achievements of modern medicine, and the most valuable contribution of this new skill has undoubtedly been to the treatment of arteriosclerosis. Both principal morphological manifestations of arteriosclerosis, aneurysmal and occlusive arterial disease, have become the subject of corrective surgical intervention, and the clinical scope of the reconstructive surgical procedures so applied has been extended to practically every anatomical subdivision of the arterial tree. Owing to the complexity of this new surgical endeavor and also because of the rapidity of its growth, there are many problems that have not been thoroughly assimilated into the fund of general medical knowledge and that, therefore, deserve a brief review. The purpose in view will not be the presentation of details but rather the summation of some broad aspects of the subject that have special significance either by virtue of their practical implications or because of their controversial character.

Case Selection in the Treatment of Aneurysms of the Abdominal Aorta.—There is hardly any dissension from the judgment that resective treatment of aneurysms of the abdominal aorta has attained an estimable place among the procedures at the surgeon's disposal. The differences of opinion do not concern the general value of these operations but rather the scope of their applicability.



The Author
D. EMERICK SZILAGYI, M.D.

The significance of this problem of applicability will be made clearer by a glance at the symptomatology of aneurysms of the abdominal aorta. The majority of these aneurysms (in our series of 260 surgically treated cases, 60 per cent) are completely free from symptoms. A small proportion causes trivial complaints such as a sensation of fullness or an awareness of abnormal pulsation. The significant symptoms almost invariably come from the pressure on the retroperitoneal nerve endings by the wall of the aneurysm when there is a rather rapid increase in its size. This *expansion* of the aneurysm causes a pain the characteristics of which are fairly constant: it is intense, boring, is located in the deep lumbar region or deep pelvis, and radiates girdle-like or downward (often into the thigh). Symptoms may also be brought about in a small group of cases by the pressure of the aneurysm on neighboring organs (ureter) or its erosion into a vertebra, hollow viscus, or large vein. Regardless of the exact mechanism of its causation or of its detailed type, pain by expansion heralds the rupture of the aneurysm. The interval by which rupture follows expansion varies from a few hours to several months, but the sequence of events is immutable. It should be stressed that unless the possibility of a pulsating mass is constantly kept in mind and its presence carefully searched for, the pain occasioned by an expanding aneurysm is very easy to misinterpret, and the error may not only lead to the initiation of unnecessary and even harmful diagnostic procedures but also to the loss of time that may be critical. Little need be said about the clinical picture of ruptured abdominal aortic aneurysms. The history is that of expansion with culmination in a prostrating surge of the pain, quickly followed by a state of hemorrhagic shock.

There is no known exception to the view that the treatment for both expanding and ruptured abdominal aneurysms is surgical intervention—as a measure of

From the Department of General Surgery, Henry Ford Hospital, Detroit, Michigan.

limited emergency for the former and as one of absolute emergency for the latter. The only limiting consideration is the assessment of the patient's ability to withstand the operation. Since there is no other than surgical treatment for their management and since both expansion and rupture of an abdominal aortic aneurysm are invariably fatal, this opinion is based on logic which is both sound and simple. The considerations are much more complex in the case of asymptomatic aneurysms.

Since an asymptomatic aneurysm *per se* is not the cause of disability or discomfort, its surgical removal has only one aim: the prevention of future rupture or, in other terms, the ultimate prolongation of the patient's life. At first glance one may think that a successful operation should invariably assure this goal since it effectively eliminates the potentially lethal lesion, and that, therefore, perhaps all asymptomatic aneurysms should be subjected to surgical treatment. However, not only do all patients with abdominal aortic aneurysms suffer from systemic arteriosclerosis, but a substantial proportion (in our series 70 per cent) of them have this disease in such form and to such a degree that it will significantly limit their life expectancy. Putting it in another way, in any given group of patients with abdominal aortic aneurysms, some will die of their accompanying (coronary, cerebral, or renal) arteriosclerosis whether the aneurysm is removed or not. This circumstance in itself may obviously reduce the value of resective treatment of abdominal aortic aneurysms. Moreover, the presence of systemic arteriosclerosis adds an extra risk to the surgical intervention in the patient bearing an abdominal aortic aneurysm, resulting in a mortality rate that is considerably higher than even that which would be expected from the magnitude of the operation.

In defining the scope of the applicability of resective treatment for asymptomatic aneurysms of the abdominal aorta, therefore, one must correlate a number of factors such as the degree of lethality of the untreated aneurysm (that is, the rate of fatalities due to the rupture of the aneurysm as distinct from the death rate of the other complications of arteriosclerosis), the operative and postoperative mortality among the patients who have had surgical removal, and the long-term survival expectancy of both the treated and untreated patients.

Reliable numerical values are now available for these factors; I shall use our own data, but the findings reported by others are in close agreement in all essential respects. According to these figures in a group of patients with untreated asymptomatic aneurysms, at the end of eight years of observation all the patients are dead, 65 per cent having died of rupture of the aneurysm and 35 per cent having succumbed to other causes, almost invariably to some complication of the associated systemic arteriosclerosis. During a similar period of time, in a similar but surgically treated group of patients the loss of life is much less. The reported immediate mortality of resection of abdominal aortic aneurysms varies (according, mainly, to the criteria of case selection) from 3 to 12 per cent, most larger clinics experiencing rates in the neighborhood of 8 per cent, which is our current operative mortality; this makes up the first part of the loss of life. During the subsequent eight years, 40 per cent of the operative survivors die, mainly of coronary or cerebrovascular arteriosclerosis. Thus at the end of the observation period, slightly less than half of the patients are dead. Conversely, the survival rate for the untreated group at the end of eight years is zero, that of the treated group 52 per cent. This is, of course, an impressive difference. The difference can perhaps be better appreciated if it is expressed in this way: a patient after the removal of an asymptomatic abdominal aortic aneurysm has six chances out of 10 to live five years, the patient with his aneurysm untreated has one chance out of 10 to live the same length of time. (One may add that a *healthy* male in the same age group has about eight chances out of 10 for the same length of survival.)

The data clearly show, therefore, that treatment by resection offers a very significant prolongation of the life of a patient with asymptomatic abdominal aortic aneurysm, and that all these patients must be regarded as potential candidates for surgical treatment. The data also indicate, however, that certain limitations must be accepted in the selection of cases for resective therapy. There certainly is a very strong argument for the exclusion from treatment of patients with severe associated arteriosclerotic manifestations, especially coronary disease. The definition of this degree of coronary disease presupposes the presence of angina that does not respond to mild or moderate medication, or the presence of recent myocardial infarction, or recurrent bouts of congestive failure. The age of the patient may also be a restrictive consideration. Since the average survival expectancy of a patient with an untreated asymptomatic aneurysm of the abdominal aorta is between two and three years, and since the life expectancy of a man of 75 with systemic arteriosclerosis is not much over three years, a patient of this age bearing an abdominal aortic aneurysm should not be subjected to an operation unless he is one of

the rare persons with relative freedom from associated arteriosclerotic disease. Surgical treatment is likewise contraindicated in patients with neurological residuals of a cerebrovascular accident or with severe impairment of renal function.

While these restrictive principles are well-reasoned and generally binding, they must at times be broadly interpreted. There is danger in becoming too deeply involved in numbers and regarding the patient as a statistic. There is, however, even greater harm in yielding to the compassion that is a natural inclination of the surgeon and attempt an operation that statistical considerations clearly show to be hopeless.

Another controversial point related to the management of asymptomatic abdominal aortic aneurysms should be briefly mentioned. An occasional study of the survival rates of operative and non-operative cases of asymptomatic abdominal aortic aneurysms has in the past been interpreted as showing that the size of an eneurysm has distinct prognostic significance. In the assesment of such an interpretation one must make clear distinction between the actual size of the aneurysm (seen at operative dissection or at autopsy) and the size estimated by the usual clinical means (palpation and roentgenographic measurement). It is the unqualified opinion of all experienced surgeons that the size of an aneurysm cannot be determined with clinical means with a margin of error less than 30 to 40 per cent and that, therefore, conclusions based on clinical estimates of the size of aneurysms cannot be accepted as valid. The gross morphological features of aneurysms strongly suggest, of course, that the larger the aneurysm the more likely to rupture since the thinner is its wall and, as a rule, the greater is the lateral pressure within it. It is, however, a common clinical observation that small aneurysms (say 6 to 8 cm. in diameter), do rupture. What is more important, it has been amply demonstrated that once a localized dilatation in the aorta (particularly when oval or circular in outline) has reached a clinically perceptible degree, that is, when it has passed that vague boundary that marks the definition of an aneurysm, it assumnes an unchanging course of progressive increase in size and will ultimately rupture unless the patient first dies of another cause. For all these reasons the smallness of an aneurysm does not in itself contradict the advisability of surgical treatment.

Choice of Surgical Technique in Peripheral Arterial Occlusive Disease.—The second great division of the clinical manifestations of arteriosclerosis, occlusive arterial disease, holds a special interest for at least two very important reasons. First, it is by far the most common manifestation of arteriosclerosis and, indeed, it is the most common of all diseases of clinical significance, being responsible for more deaths than any other three causes combined. Second, until the advent of surgical methods, this disease was essentially untreatable. The most frequently seen form of occlusive arterial disease, by a wide margin, is that affecting the peripheral arteries.

To see clearly some of the problems that engage the attention of the surgeon in dealing with peripheral arterial occlusive disease, one must recall the anatomical circumstances that render surgical treatment at all possible. Contrary to the concepts taught some years ago and still tenaciously surviving in some texts, the extensive angiographic investigation of arteriosclerotic patients during the past 15 years have clearly shown that the pathological processes that create the morphological lesion of arteriosclerosis are segmental. This is, in fact, a surprising phenomenon since the fundamental etiological factors so far implicated, with varying degrees of justification, in the causation of arteriosclerosis are systemic: hormonal, metabolic, racial, and hereditary. The pathological alterations that make up the arteriosclerotic process (intimal thickening with fibrosis and atheromatosis, medial degeneration with or without calcification, and chronic adventitial inflammatory changes) are indeed diffuse and involve to some degree the whole extent of all the arterial trunks, but their intensity is so variable that they often leave long vascular sections virtually free while completely engrossing others. This accentuation of the occlusive process is generally determined by local anatomical factors: changes in dimension in the vessel, presence of branching, or paucity of the vasa vasorum. When the obliterative process (principally the intimal fibrosis or atheromatosis) at any point leads to a degree of narrowing that exceeds 70 per cent of the original lumen, not only do clinical symptoms appear but the velocity of the blood flow is sufficiently reduced to initiate a chain of events that sooner or later results in thrombosis and complete closure of the lumen. It is a critical fact that the atheromatous or fibrotic stenosis is of very limited extent in the longitudinal axis of the artery: usually only 2 to 3 cm. in length. As the result of the obliteration of these narrow segments, however, a much longer portion of the involved arterial trunk will be put out of function: the stagnation of blood flow will cause thrombosis both distally and proximally to the point of occlusion over a length determined by the distance to the next major collateral branch that will be capable of providing a wide enough

channel to maintain the minimal necessary velocity of blood flow. For instance, when the common iliac artery is obliterated by intimal disease, the subsequent clotting invariably extends proximally to the aortic bifurcation and distally to the femoral bifurcation leaving both superficial and deep femoral arteries open (if not otherwise diseased); occlusion of the superficial femoral artery anywhere along its course below its origin characteristically will result in its complete thrombosis as far distalward as the superior geniculate branch, and often even further. By the coupling of these obliterating events at multiple points in course of a long arterial axis, a whole series of segments may become occluded and in essence the entire arterial trunk may become functionless (for example, the entire ilio-femoral arterial trunk from the aortic bifurcation to the division of the popliteal artery, or even lower). As a rule, however, there are "skip areas" between pairs of occluded segments, and this is the fact that makes it possible for the surgeon to intervene. By bridging one open segment with another through a graft, or by removing the obstruction with thrombo-endarteriectomy between two open segments, he may restore a normal or at least greatly improved blood flow.

It will be self-evident that the maintenance of patent arterial segments sandwiched between areas of obliteration depends, in the first place, on the existence of arterial branches to serve as new pathways for the diverted blood. The more abundant these branches the better the patient's compensation to the arterial obstruction, the less extensive the secondary thrombosis and the more promising the surgeon's task. To a large extent, the availability of these potential collaterals is anatomically determined. They are abundant at the aorto-iliac level, less rich but adequate in the upper thigh, poor around the knee, and almost absent in the leg and foot. In close correspondence with these anatomical facts, reconstructive arterial operations in general are less effective the further distalward one proceeds from the abdominal aorta.

A question that has been the subject of much agitated controversy among surgeons in recent years is whether grafting or endarteriectomy is the superior technical method in the correction of occlusive lesions. Advantages and disadvantages can be listed for both. Basic considerations would suggest that endarteriectomy is the more nearly physiologic procedure: it removes the obstructing lesion and leaves an arterial wall that is not only strong enough to function but is capable, through a healing process, of returning to a state amazingly close to normal (at least for a time). In contrast, at the present state of our skills, in substituting for an occluded artery, the grafts used are usually of the synthetic type and their insertion is in essence the same as implanting a foreign body—a deed contrary to time-tested surgical principles. On this score, grafting clearly seems to come off second best. When, however, aside from *a priori* concepts, one looks at the clinical problems involved in the use of the two methods and at the results they have produced, the rating of the two methods becomes less simple. Those who have given extensive trial to both methods (as did the author) have encountered serious technical difficulties with endarteriectomy when the technique is applied to long segments of arteries of small diameter such as the external iliac, femoral and popliteal arteries. When dealing with arteries less than 8 mm. in diameter, not only is the procedure demanding of fastidious attention and much time but it is often followed by thrombosis unless regional heparinization (with its costly and cumbersome details of bedside care) is maintained. Now, one of the fundamental rules of the techniques of endarteriectomy is that the dissection must be carried distally to the outermost limits of the gross occlusive involvement; if any stenotic area is left in the path of the blood flow, the blood in the proximal endarteriectomized segment is certain to clot. Because of this requirement, it is rarely possible to avoid carrying the endarteriectomy to the femoral region when dealing with aorto-iliac and to the popliteal segment when dealing with femoral disease by this technique. Yet, while in an inordinate amount of time and effort must be spent on the operative procedure and postoperative care, the *immediate* postoperative patency rate is relatively low: around 80 per cent in the aorto-iliac and 70 per cent in the femoro-popliteal area (the comparable figures for grafting being at least 10 per cent better in the aorto-iliac and 15 per cent better in the femoro-popliteal area). There is no doubt, however, that the gradual deterioration of the results in the later postoperative period is less after endarteriectomy, especially in femoro-popliteal cases. As regards grafting procedures, the qualities of economy of time, simplicity of technique, and the excellent early results are most attractive, but these are counterbalanced by the less stable later results (particularly after femoro-popliteal operations) and a small but not insignificant incidence of healing complications related to plastic implants.

To this author, it seems a logical compromise to use endarteriectomy whenever it can be limited to the aorto-iliac segment and to employ grafting operations when the disease extends further distalward. In

about 25 per cent of the cases of aorto-iliac disease, the obliterative process virtually stops at the common iliac bifurcation and in these cases endarteriectomy is an almost ideal corrective method. When the aorto-iliac obliterative lesion extends into the external iliac-common femoral segment, but still leaves the common femoral patent (which is the case in over 60 per cent of all the instances of aorto-iliac disease), bypass grafting from the aorta to both common femoral arteries is a very effective operation. In the cases of femoro-popliteal involvement in which surgical correction is demanded (which by our current criteria form a limited number), grafting appears to have a distinct advantage—an advantage, however, that more extensive statistical studies on endarteriectomy may disprove.

Perhaps the sharpest division of opinion in the entire field of vascular surgery has arisen in relation to *the operative indications for femoro-popliteal occlusive disease*. The views expressed range from denying all usefulness of reconstructive procedures in this area to the advocacy of the standard bypass operation for all grades of intermittent claudication. The variance in attitudes stem mainly from the differences in operative results. Those reporting excellent success (in the range of 80 per cent patency after three years) see no reason to restrict their operative indications, while a few among those whose late *failure rate* has reached 80 per cent in three or four years have lost all confidence in direct surgical attack by grafting.*

The opinion of most surgeons (including that of the present author) falls between these extremes undoubtedly because their operative results likewise fall somewhere in the mid-range. Meaningful figures are not easy to find but in general the overall experience seems to parallel our own, which shows that starting out with an immediate postoperative patency rate of about 80 per cent, the results of femoro-popliteal bypass operations utilizing plastic prostheses steadily decline year by year, the patency rate reaching 40 per cent in three years and about 20 per cent in five years. (It should be added that the results of femoro-popliteal endarteriectomies cannot be evaluated since comparable figures are completely lacking.) These are obviously not results to inspire enthusiasm. Moreover, when one searches for the causes of these late failures one finds that they are not generally remediable. The use of autogenous vein grafts may correct the shortcomings of the synthetic prostheses, but the more frequent causes of poor late results, namely the progression of the disease process and the inherent unfavorable anatomical characteristics of the popliteal arterial trunk and its branches, cannot be corrected. Some narrowing of the scope of the clinical application of grafting procedures in femoro-popliteal disease would, therefore, be well indicated. In deciding about the precise area in which the retrenchment should take place, an important circumstance to take into account is that the degree and type of femoro-popliteal occlusive disease causing intermittent claudication as a rule is a benign and relatively nonincapacitating disease. The withholding of surgical treatment from this group of patients creates very little hardship. On the contrary, in cases with severe ischemia—that is, with symptoms of rest pain or pregangrenous tissue changes—the future of the affected limb, and with it the patient's livelihood, is in very serious jeopardy. If, in these advanced cases, one can prolong the useful life of the limb even by two or three years, one brings about a great deal of benefit to the patient, and in fact this modest goal—two to three years of patency—can be accomplished in well over half of the cases of severe femoro-popliteal occlusive involvement.

In view of these considerations, the use of reconstructive procedures by grafting in the management of advanced femoro-popliteal arterial disease seems well justified. Grafting for calf claudication, on the other hand, should be performed only if the symptoms are rapidly progressive and the degree of incapacitation is such as to threaten the patient's means of livelihood.

Value of Arterial Substitutes.—In no other area does the surgeon dealing with vascular problems see his goal more clearly and has been less successful in attaining it than in the area of arterial substitution.

When, about five years ago, arterial homografts were shown to be grossly deficient (mainly for reasons of immunological incompatibility), a great deal of interest arose in arterial prostheses made of plastic fibers. On grounds of very extensive laboratory investigations the essential qualities of a satisfactory arterial substitute were gradually formulated, a number of plastic prostheses were evolved, and several such substitutes were put to use in actual clinical practice. All acceptable plastic arterial substitutes have the following qualities in common: they are porous by virtue of being either woven or knitted; the plastic fiber forming the fabric is histologically inert and physically durable; and the textile construction is such that the implant is flexible or even elastic. In

*This exceedingly wide range of operative results can only be explained on grounds of the variable completeness of follow-up and of the dissimilarity in the criteria of success.

addition, the prostheses possess certain practical characteristics such as ease of handling, storage and sterilization. Porosity is essential since the invasion of the wall of the prosthesis by connective tissue, which is the essential part of the formation of the new artery, depends on the presence of this condition. Tissue inertness is sought since without this quality, the implant would be sequestrated and under certain conditions extruded. Durability is an obvious requirement. Flexibility is needed in order to allow the molding of the implant to the contours of its environment; this important quality has been achieved by various means: by knitting, by crimping or pleating the wall, or by constructing part of the fabric from specially elasticized yarn (as in the prosthesis developed by the author). Two plastic substances have been found to yield fibers suitable for the construction of prostheses meeting the requirements listed: Dacron and Teflon, and of these Dacron appears to be superior in several important respects.

At least four types of plastic arterial substitutes have now received extensive clinical trials, three made of Dacron and one made of Teflon. (It is estimated that upwards of 30,000 such prostheses have been implanted in patients.) Judged from the reports of their users, all four have served well. Indeed, most of the reports constitute an almost unqualified endorsement of these synthetic implants.

A critical study of the present author's material, both clinical and experimental, and including over 600 operative cases, has, however, yielded findings that give reason for misgivings regarding the future role of synthetic arterial prostheses. Briefly stated, arterial substitutes of plastic fibers—in spite of their superior tissue inertness—are not free from the outstanding shortcoming of other buried nonabsorbable materials, that is, the propensity of enhancing and perpetuating wound contamination of otherwise subclinical importance. This property in synthetic arterial prostheses, however, has a more ominous significance. In order that a plastic arterial implant may function properly, the ingrowth of connective tissue into the fabric must be prompt and thorough. If the ingrowth fails, the textile tube is subject to distortion of its shape, to leakage or to thrombosis, but in any case to eventual malfunction. It has been observed that this process of connective tissue invasion of the implant (or arteriogenesis) is very easily disturbed by both minimal infection in the wound and any other abnormality of the tissue bed. Degrees of contamination that ordinarily have no clinical significance, as well as relatively small collections of blood or serum, will extensively interfere with the process of arteriogenesis and eventually lead to the loss of usefulness of the prosthesis. We have found it possible to detect and follow changes of this character in serial angiograms of arterial implants. Although the incidence of changes of this type that will ultimately cause serious clinical concern is low (about 15 per cent), their appearance is a disquieting addition to the list of problems confronting the surgeon.

It is doubtful that the defects of synthetic arteries can be entirely remedied by search for newer plastic fibers or by modification in the structure of the existing prostheses. Nor is the use of autogenous vein as arterial replacement a complete answer. Autogenous veins no doubt are the best currently available arterial substitutes but the scope of their usefulness is sharply curtailed by their limited source of supply and restricted applicability. The only veins that are available for autogenous use are the saphenous, brachial, and inferior mesenteric and they can only be used in the replacement of arteries of 8 to 12 mm. in diameter.

The "ideal" arterial substitute would be an autogenous or a nonantigenic homologous vessel with such wide range in size and configuration as to permit its insertion in any part of the arterial tree. The advent of such an arterial substitute, along with that of homologous tissue transplantation, lies somewhere in the dim future. In the meantime, the demonstrated sensitivity of the available synthetic arteries to wound contamination and tissue damage re-emphasizes the importance of fastidious surgical technique in performing reconstructive vascular procedures.

Health Balance Sheet

Diseases which killed, crippled and permanently invalided their victims have been controlled, or are a thing of the past, because of the discovery and development of pharmaceutical products unimagined a quarter of a century ago. The balance sheet of health is something which can never be expressed in money terms. Against any reckoning of money or of effort has to be set the incalculables: The young life which is not lost but grows to fulfillment; the worker restored to productive life; the mother who does not die in childbirth; the breadwinner who goes on winning bread.—Ritchie Calder in "The Life Savers," 1962.

Frederick Amasa Coller: An Appreciation

Alexander Blain, III, M.D.
Detroit, Michigan

THE IMPACT of Doctor Coller's teaching in Michigan, throughout the country, and, indeed, throughout the world, has been truly impressive. This has been illustrated in the recent publication of the Frederick A. Coller Commemorative Issue of *Annals of Surgery* (154:December, 1961).

Frederick A. Coller was born on October 2, 1887, in Brookings, South Dakota. His father, Dr. Granville James Coller, member of an old Michigan family, received his medical degree from the University of Michigan in 1880 and, after postgraduate study in New York, moved with his family to Brookings, which was then the end of the line of the Chicago and Northwestern Railroad (to which railroad he later became surgeon). Dr. Frederick Coller once said that hardly anyone was born in Brookings, while in Rochester, Minnesota, only 232 miles away, hardly anyone was supposed to die.

The future Dr. Frederick Coller, after a public school education, spent the years 1902-1908 at the South Dakota State College, where he earned his B.S. and M.S. degrees, the latter in chemistry. He was a good athlete in college and could run the 100 yards in 10 seconds. He then attended Harvard Medical School, where he came under the influence of such outstanding scientists as Cannon, in physiology; and Folin, in chemistry. In medical school, he earned many honors, including election to Alpha Omega Alpha and the Class Presidency, 1909-1910. He graduated cum laude and was appointed intern on the west surgical service at Massachusetts General Hospital in July, 1912. Following internship, he was appointed the first resident in surgery at the Massachusetts General Hospital.



The Author
ALEXANDER BLAIN III, M.D.

In April, 1915, Doctor Coller, under the leadership of Dr. Harvey Cushing, went to France to take over one of the surgical services of the American Ambulance in France. This service, a war-time institution of 600 beds, developed by the American Hospital in Neuilly, was set up to care for wounded French soldiers.

In 1917, the United States having entered the war, Doctor Coller was drafted as a private and shipped to Camp Lewis in Washington. Here, he married Jessie Edwards Bernson, a Vassar graduate, on December 19, 1917, so that this experience is remembered by him with a great deal of affection. While abroad with the 91st Division, 1918-1919, Major Coller participated in the St. Mihiel, Argonne, and Lye-Scheldt offensives. After the war, he was called to Ann Arbor to serve under Dr. Hugh Cabot, who had become Professor of Surgery at the University of Michigan in 1919.

Dr. George C. Adie,[2] of New Rochelle, New York, quotes one of Doctor Coller's first residents as saying,

"Dr. Cabot, then Professor of Surgery and later Dean of the Medical School, was too busy with reorganization of the Department, the School and the Hospital to give proper and adequate direction to the surgical service. The younger men were looking for leadership and found it in Fred. His athletic achievements, fine physical appearance, charming personality, and exceptional scholastic and professional background (especially for those days), endeared him to the entire staff. He was a constant student of medical literature and had an intense interest in medical history. He could also find time for relaxation and good fellowship. He never let down a friend or a student and insisted on fair play. And with all this, he was never too busy to be chiefly concerned with the sick human being."

Presented at a meeting of the Prismatic Club, Detroit, April 28, 1962.

Doctor Blain is Clinical Assistant Professor of Surgery, Wayne State University College of Medicine, and Surgeon-in-Chief, Alexander Blain Hospital, Detroit.

The following observations will make obvious why, to a man, Doctor Coller's resident surgeons say, "I am proud to be a Coller man."

Scientific Contributions

Doctor Coller's first published surgical paper was entitled, "Fractures in a Base Hospital" and appeared in the Boston Medical and Surgical Journal in 1916. In 1925, he published four articles. Two of these were on the subject of goitre. In one of these (published with Howard B. Barker, in the JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY), his title indicated a conclusion. It was "Endemic Goitre: A Precancerous Lesion."

He and his surgical department achieved great prominence, partially as a result of over 180 papers from 1924 through 1961, dealing with *Surgical Physiology* (fluids and electrolytes); *Cancer* (particularly modes of metastatic spread and his technical results with the one-stage combined abdominal-perineal resection for lesions of the sigmoid and rectum); *Peripheral Vascular Physiology and Surgery* (particularly the roles of vasoconstriction and vasodilation in pathogenesis and treatment of vascular diseases); *Thyroid Surgery* (particularly his technique of thyroidectomy); *Peritonitis* (experimental and clinical); *Surgical History*; *The Popularization of Transverse Abdominal Incisions*; *Shock and Blood Loss*; *Surgery of the Spleen*; and *Pre- and Post-Operative Surgical Management*.

Many of these papers reflect with clarity the tremendous clinical and research experiences in his department, and some of them have represented great strides in the scientific advance of surgery during his teaching career.

Among his honorary degrees and awards were: D.Sc., South Dakota State College, 1949; Theodore McGraw Medal, 1950; LL.D., Hampden-Sydney College, 1952; D.Sc., Washington University, 1957; Evarts Graham Medal, 1957; and LL.D., University of Michigan, 1959.

Doctor Coller was President of the American Surgical Association in 1943-1944, and of the American College of Surgeons in 1949-1950. In 1959, he was Vice President of the Societie Internationale de Chirurgie (Bruxelles).

He has been Visiting Professor of Surgery at the University of Virginia, Harvard, Ohio State, University of Washington, Nebraska, Washington University, Marquette, and the Universiay of Missouri. In addition, he has given many distinguished lectures, among which are the Judd Lectures, University of Minnesota; Porter Lectures, University of Kansas; and the Dallas B. Phemister Lectures, University of Chicago.

Doctor Coller served as medical advisor to the Armed Forces during World War II. He was active



Crest of the Frederick A. Coller Surgical Society, taken from a notable medieval manuscript: *The Rosa Medicinae (Anglica)*, by John of Gaddesden, A.D. 1314. John of Gaddesden was the first Englishman to be Court Physician to an English monarch and is praised by Chaucer who, in his prologue to the Canterbury Tales,[5] puts Gaddesden's name with Hippocrates, Galen and Avicenna.

in the American Board of Surgery and on committees of the American College of Surgeons in improving surgical training in American medical schools and hospitals.

Here in Michigan, two institutions bear Doctor Coller's name. The first of these is the Annual Coller-Penberthy Meeting which has been held for many years at Traverse City. These meetings were inaugurated by Dr. Edwin Thirlby to serve as an annual refresher course for practicing physicians in the northern part of the state and are held each July.

The second institution is the Annual Ann Arbor Meeting of the Michigan Committee on Trauma and Nutrition of the American College of Surgeons. At this meeting, residents in surgery from the approved training hospitals throughout the state present original papers in these fields in competition for the Annual Frederick A. Coller Award.

The Coller School of Surgery

A school of surgery, to be significant, must have as its head a master surgeon. By this is meant a man of exceptional technical ability and also the ability to teach, to investigate, and to inspire his pupils to emulate him. The first such school in this country was

that of Halsted, at Johns Hopkins University, which was modeled after that of Billroth, and others in Germany and the continent.[3] Doctor Coller was influenced by Cushing, one of Halsted's first resident surgeons.

After World War II, Doctor Coller trained many resident surgeons. Many of these men had just returned from active military service and, frequently, from combat in World War II. This backlog of trainees lasted for several years but was skillfully managed by a system of farming residents out to other hospitals also rich in surgical material, including even the hospital at Jackson Prison. Men were also assigned for periods to the anatomy, pathology, and research laboratories, to anesthesia, and other departments where valuable experience could be obtained.

To the amazement of those who did not understand the method of training so many simultaneously, and who knew only the Halsted System (which, at that time, meant one or two senior surgical residents in hospitals of even more than 1,000 beds), the Coller School of Surgery turned out more than 200 residents in the 37-year period, 1920-1957.*

Doctor Coller's departure from the goal of training only professors of surgery was a boon to the state of Michigan, which now has well-trained surgeons in almost every sizable community, frequently products of the University of Michigan and the Coller School of Surgery. This was certainly not the case when he began teaching in 1920. It is of interest also that, in spite of this departure, so many products of Doctor Coller's training program have become Professors, Associate Professors, Assistant Professors, and Chiefs of Surgery throughout this country (and a few in other countries, as well).

In July, 1957, Doctor Coller became Professor Emeritus of Surgery at the University of Michigan and, together with his associate, Dr. William J. Regan, is carrying on his private practice at the St. Joseph Mercy Hospital, Ann Arbor.

The graduates of the Coller School of Surgery are a memorial to the greatness of Doctor Coller. Moreover, through their practice and teaching they are carrying on his high standards of surgery and surgical training for the benefit of the sick throughout Michigan and elsewhere.

Surgery has been considerablye enriched by his career. Doctor Coller has accelerated beyond measure the advance of surgical science, begun in this country by William Stewart Halsted.

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*It is of some interest that the contributors to the Harvey Cushing Birthday Volume of the *Archives of Surgery* (April 8, 1929), numbered some 82 surgeons, associated with Doctor Cushing in the 20-year period, 1909-1929.

Doctor Reports "Late" Babies Are Okay

A Michigan obstetrical professor contends that the added risks of prolonged pregnancy are far less than the possible dangers of interrupting that pregnancy.

Tommy N. Evans, M.D., Ann Arbor, reported on a study of more than 20,000 deliveries at the University of Michigan Medical Center in an 18-year period, of which nearly 9 per cent (1,721) lasted two weeks or more beyond the expected time. He gave his report at the recent session of District V of The American College of Obstetricians and Gynecologists in Indianapolis.

Doctor Evans pointed out that among the infants "born late," there was "no significant difference in the death rates between this group and the infants born between 37 and 42 weeks." He stressed that "the added risks of prolonged pregnancy are slight and can be made even less so by vigilant obstetric and pediatric management. The conservative management of uncomplicated prolonged pregnancy seems preferable to interruption by either drug stimulation of labor or by Cesarean section." He also pointed out that none of the deaths was associated with noticeable malnutrition in the "late" baby, contrary to popular belief.

He concluded that this study "identifies prematurity as a far greater hazard than postmaturity."

Teacher-Surgeon—The Man

He has been a teacher in the finest sense of the word.

He has been a great clinician with a surgical technique infinitely fine and delicate.

He has been an inspirational and colorful leader to the several hundred surgical residents he has trained and sent out all over the world to carry on in his tradition of enlightened, moral and scientific dedication.

His friendship for "his boys" has been warm and lasting. He has been quick to praise their worthy achievements but equally caustic for their inexcusable errors.

He has been a shining light in the University of Michigan and will so remain through the oncoming years.

He has been a surgical giant in a world peopled with many great surgeons.

He is Dr. Frederick A. Coller, longtime head of the surgical department of the University and to whom this issue of THE JOURNAL is dedicated.

He is the teacher to whom I am deeply grateful for my early surgical training.

RUSSELL L. MUSTARD, M.D.
Battle Creek

"The New Physician"

Much is written about changing medicine but perspective is frequently missing.

It was Hippocratic medicine that initiated the modern era by recognizing health and illness as natural rather than supernatural events. This concept evolved as knowledge grew of the structure of man and of Nature. For 250 years after Versalius, medicine and the biological sciences were revolutionized by accurate observation, description and classification. The decline of the city-state with the rise of nationalism; the impact of the Reformation and the devolping industrial revolution provided a background of social changes as dramatic as those we see today.

Less than 100 years ago Claude Bernard contributed to this evolution by providing the principles of experimental medicine. It is only within the last 30 years and principally since World War II that experimental medicine has had the means of being objective, quantitative and verifiable; instead of subjective, descriptive and empirical.

The unity of the individual is threatened by this scientific revolution as surely as his individuality is threatened by the economic, social and political patterns of our time. However, we can no more return to 19th century nationalism and the American political structure of that time than we can recapture the role of the physician of



that era. The purposes of our predecessors are our own, but the nature of their efforts was an expression of their time and not ours.

The need of medicine today is to adapt to the scientific, social and economic realities of our era while preserving its historic compassion and its loving concern for each human being. The need of the physician is to provide to an ever-increasing number of patients the full fruits of modern scientific medicine while retaining his historic responsibility for ensuring that *his* patient is receiving those health services that are needed.

These needs are creating a new role for the physician. It is not enough that he give full expression to the humane concerns that identify medicine; neither is it enough that he also be a continuing student of medical science; he must, for the future, also synthesize and integrate the knowledge and services of *all* those who can contribute to his patient's well being. In this development, it is inevitable that the physician's role will change from that of pure "production worker" to one where "managerial" functions are of high importance.

Medicine has lost the place of the comprehensive general practitioner of fifty years ago. The general internist is rapidly being replaced by emphasis or restriction of practice to a medical specialty. The general surgeon has an ever more sharply restricted domain and the general pediatrician seems to be following the same patterns as the internist. The need for the "new physician" is evident. A clear definition of his place in the existing organization of community medicine is not available; neither is it clear how the "new physician" can obtain training without this place being created so he will have an opportunity for effective work. His development is necessary, however, if the specialist's role is to be most effectively fulfilled and the historic patient-physician relationship preserved. In this development the joint effort of organized medicine, medical education and community hospitals is required.

W. N. Hubbard, Jr., M. D., *Dean*
University of Michigan Medical School

Helping Future Michigan M.D.s

Michigan doctors of medicine should be proud of the job they are doing to provide financial assistance to medical students through the Michigan Foundation for Medical and Health Education, Inc.

The Michigan doctors who have contributed to the Foundation certainly can take special pride!

The Michigan doctors who have intended to contribute, but haven't, should consider taking out their checkbook and making that special contribution now.

Ever since its formation in 1945, the Foundation has filled a special need in the state.

Closely identified with the success of the Foundation is Earl Ingram Carr, M.D., of Lansing, who has served as president these 18 years. At the recent Annual Meeting of the Foundation, the members adopted a special resolution to provide a standing ovation for this dedicated doctor of medicine!

The previous day, Doctor Carr had received a MSMS citation "Distinguished Health Service Award" from MSMS for his "brilliant leadership and years of self-sacrificing service to the Foundation." The citation pointed out "You have by your dedication successfully advanced its purpose—to acquire, provide, use, develop, endow and finance methods, means and facilities for postgraduate education in medicine, for education in medicine, for lay health education, and for research, fellowships and scholarships."

The optimism of Doctor Carr was sounded in his 18th Annual President's Report, when he commented, "With money, the potential scope of activities, possible and appropriate, for this Foundation is vast." Doctor Carr continued, "The Foundation belongs to the Doctors of Michigan—it deserves their support."

Doctor Carr observed, "The Michigan Foundation plan has been the most liberal in the nation, and equivalent to a well-to-do parent or a benevolent friend . . . If an energetic, frugal young man borrows from our Michigan Foundation, he has the opportunity to escape all interest or cost of any kind."

It is interesting to note in Doctor Carr's report, that the Student Loan Fund of the Foundation has extended loans to 22 young medical students, and that eight of these have been completely repaid. In addition to the loan fund activity, the Foundation annually provides a grant of $1,000 towards the cost of the Michigan Health Conference, held in Ann Arbor in 1962 by the Michigan Health Council. In 1962, the Foundation made grants of $600 each for research fellowships to the medical schools at the University of Michigan and Wayne State University. The Foundation also provides the annual Biddle Lecture as part of the MSMS Annual Session. The 1962 Biddle Lecture was given by J. S. DeTar, M.D., of Milan, and the MFM&HE Lecture at the annual Michigan Clinical Institute in 1962 was given by George Crile, Jr., M.D., of Cleveland.

Action taken at the Foundation's annual meeting will help to assure greater interest and participation in this excellent project. In future, the annual meet-

ing will be held in conjunction with the MSMS House of Delegates meeting, a change concurred in by the Delegates in 1962. Companion action also provides that the seated delegates shall become members (similar to stockholders in a profit-making corporation) of the Foundation.

As we all look ahead to greater service by the Foundation, it is proper to note the sincere words of Doctor Carr, who commented: "The accomplishments of the Foundation have been possible through the generosity of a few." Soon, a mailing—authorized by the 1962 House of Delegates—will be made to provide every MSMS member with another opportunity to contribute to the Foundation. The doctors of medicine in Michigan should and will respond generously to help assure the advancement and expansion of this worthwhile effort.

Telling Medicine's Story

The need to tell Medicine's story is stressed by officials of the AMA and MSMS—and surely every member will hear this plea again and again. AMA President Fister makes this appeal in his article on Page 151, and AMA Assistant Executive Director E. B. Howard issued the same challenge at the MSMS Annual Seminar in Lansing, January 24.

MSMS pledges to help tell the story at every opportunity. One of these opportunities was the recent publication by the *Detroit Free Press* of a special magazine section, *Impact*.

The MSMS message to thousands of readers is one that every doctor can be proud to repeat. The MSMS-sponsored advertisement in *Impact* stated:

OUR GOAL IS YOUR GOAL

Improving the health of the people and the alleviation of suffering is the end goal of the medical profession.

As the individual doctor of medicine feels a deep responsibility for his patient so does the medical society feel concern for the public.

In consequence a specific program coordinating the profession on the local, state and national levels with all health-minded groups is directed toward:

(a) Complete coverage of the state by local health departments,
(b) Increased basic research grants,
(c) Lowering maternal mortality,
(d) Guarding child health by immunization, early detection and disease control programs, including fluoridation,
(e) The establishment of psychiatric and rehabilitation units in hospitals,
(f) Care for the aged,
(g) Increasing the number and improving the placement of doctors.

Today the finest medical care is available to members of a free society in Michigan under a voluntary system unmatched anywhere for its effectiveness. We seek your interest, your advice and your support to keep it that way.

Community Participation Counts

The progress of the medical profession in the nation and the state, depends upon the concerns and action of the component medical societies on the local level—and also upon the individual doctors.

This point was driven home effectively at the "Annual MSMS Seminar—on Community Relations" held in Lansing, January 24. Despite frigid temperatures, more than 125 leaders of component medical societies participated in the Seminar.

The component medical society leaders went home with many solid suggestions for work in the "Community Relations" field. Among the possibilities are:

1. Encourage every MSMS member to become more active in civic affairs.
2. Urge all members to be more concerned with quality education for every child.
3. Develop patterns of cooperation with such community organizations as the Chamber of Commerce, the PTA, the women's clubs.
4. Urge country society to launch positive projects in such community service fields as safety, youth fitness, career recruitment, self-help courses.
5. Encourage the new county society Socio-Economics Committee to study the operation of MAA in your county.
6. Be sure your legislative committee is working.
7. Help your public relations committee to explain to the community the hopes and goals of doctors of medicine.

Many, many challenges face medicine today. The AMA and your Michigan State Medical Society are eager to face up to them. The AMA has many purposes and goals on a national level. But the AMA must depend upon the component medical societies. The AMA cannot effectively campaign against cancer quackery in the many communities across the nation. The AMA cannot work effectively on a legislative problem unless there are warm, honest friendships between legislators and their hometown doctors and I could cite many other instances.

These same limitations are certainly true with the Michigan State Medical Society. The MSMS House

of Delegates may wish that doctors of medicine be more active in youth fitness projects, but nothing will happen unless our 55 component societies move in this field. Nothing will happen to encourage medical self-help courses in Michigan unless your component societies go home and set up committees. MSMS Committees can offer assistance in many fields, but the offer is meaningless unless your county society leaders decide to utilize such technical guidance and help. The MSMS Legal Affairs Committee may wish to acquaint new legislators with the views of medicine, but this cannot be productive unless the county societies have liaison committees at home, or unless you come to Lansing to confer with your representatives. It would be easy to list many other examples.

The capable MSMS Councilors and staff members are eager to visit each county society to provide assistance from time to time on Community Affairs. Much help is available.

No longer is it enough to practice the best possible medicine every day with every patient. It is imperative that each doctor participate in community projects, and the leadership must come from the component medical societies.

—Robert J. Mason, M.D., *Chairman, MSMS County Societies Committee*

Your County Medical Society

With the present-day trend toward all physicians being specialists in a limited field of the art and science of medicine, it is only natural for the specialist to become interested in those organizations devoted to the interests of his own specialty group. When physicians devote too much of their time and effort to their own individual practice and specialty interest, we find it most unfortunate and at the same time, detrimental to the interests of all, when this trend restricts our common ground.

The various pressures now being applied appear, in the minds of some of us, to be directed toward influencing us to accept employment by big government, big labor or big business. When such pressures are created, they can best be dealt with by a unified influence of all of us. The American Medical Association's primary interest is in those matters influencing medical practice on a national level, while the interest of our state medical society is primarily devoted to those matters peculiar to our state which affect medical practice on a statewide basis. Your county medical society, however, is primarily interested in the forces and influences peculiar to our own county as they influence the conduct of medical practice right at home.

It is most desirable that each of us are offered active package membership in these organizations that are so carefully integrated to deal with all influences which tend to affect the conduct of all forms of medical practice. This national, state and county package membership is our bulwark of organized medicine. It is essential that we prevent chaos by jealously protecting and strengthening these most essential organizations. The fundamental unity of physicians enables us, in turn, to seek membership in those organizations devoted to our own special interests and thereby bring about an arrangement for all of us to fully intensify our educational needs and desires. In addition, we can make our individual contributions to medical investigation and education.

Local support of the county medical society and its affiliates in organized medicine can be affected only through enthusiastic attendance and participation in local society functions.

Your lack of attendance at meetings, when it actually exists, is our most serious fundamental problem and is also a serious drawback in the endeavors of your local society to attain their objectives.

H. B. Elliott, M.D., *Past President, Genesee County Medical Society,*
Vol. 35, No. 1, Genesee *Bulletin*

Thank You, Doctor Mustard

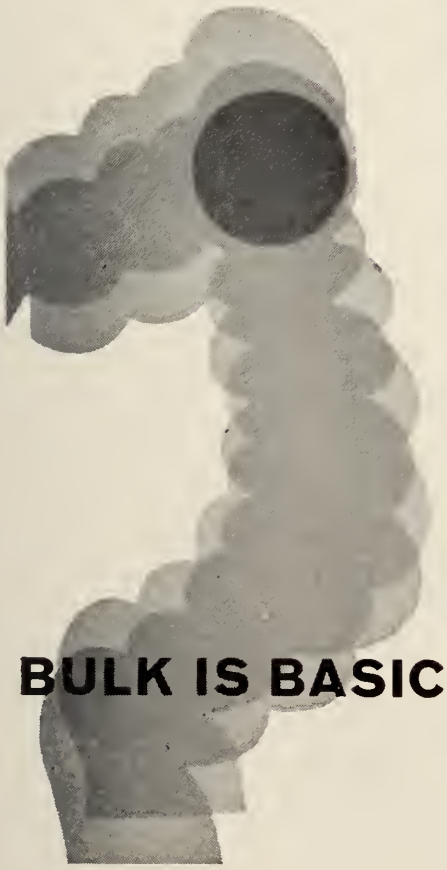
The clinical articles in this number of The Journal MSMS were coordinated by Russell L. Mustard, M.D., of Battle Creek. He also wrote the Guest Editorial which leads off this Editorial section. We sincerely appreciate his cooperation in the preparation of this number, dealing with Master Surgery.

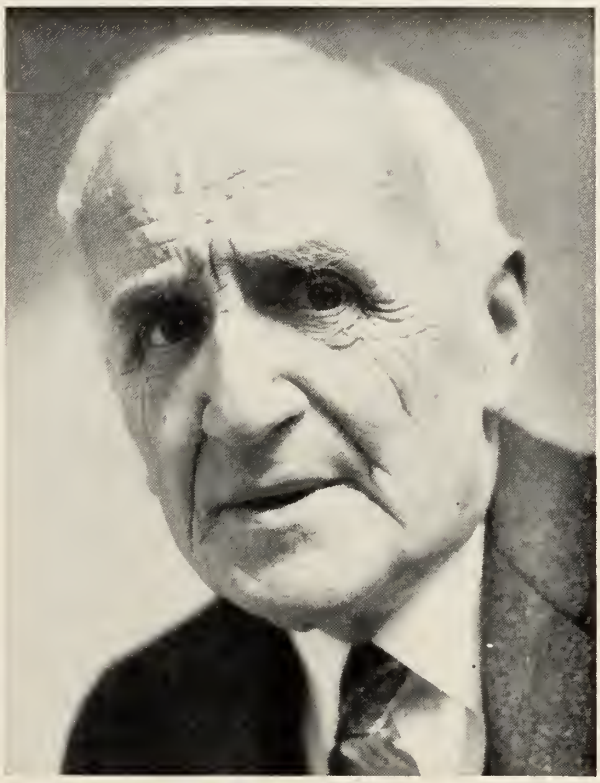
The Editor

Neurological Surgery in a Medical Center

(Continued from Page 183)

21. Schneider, R. C., and Crosby, E. C.: The interplay between cerebral hemispheres and cerebellum in relation to tonus and movement. J. Neurosurg. (Accepted for publication Oct. 8, 1962).
22. Schneider, R. C., and Crosby, E. C.: Afferent cortical connections to the rhinencephalon. Presented at the Third International Neurobiology Symposium, Kiel, Germany, Sept. 25, 1962. (To be published in volume edited by J. P. Schadé, Elsevier, Amsterdam.)
23. Schneider, R. C., and Crosby, E. C.: Inaccuracy in localization of expanding intracranial lesions of the temporal lobe. (To be presented at a combined meeting of The British Neurosurgical Society and the Neurosurgical Society of America in London, June, 1963.)
24. Spiegel, E. A., and Wycis, H. T.: Ansotomy in paralysis agitans. AMA Arch. Neurol Psychiat., 71:598, 1954.
25. Wycis, H. T., and Spiegel, E. A.: Ansotomy in paralysis agitans. Confinia neurol., 12:254, 1952.





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Metamucil, refined hydrophilic mucilloid, is especially suited to correct the kind of constipation most frequently encountered in elderly patients.

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*Each tablet contains phenylephrine HCl 10 mg., phenylpropanolamine HCl 40 mg., phenyltoloxamine citrate 15 mg., chlorpheniramine maleate 5 mg.—half in the outer layer, half in the sustained-action core. Each teaspoonful (5 cc.) of Naldecon Syrup contains the equivalent of one-half tablet.

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but it can help you relieve the suffering of your patient in PAIN . . .

by reducing the anxiety and fear that intensify pain

by potentiating analgesics—enabling you to reduce narcotic dosage by 50 to 75%

and by controlling nausea and vomiting.

'Thorazine' is particularly useful in the severe pain seen in your cancer, surgical, and obstetrical patients. It is available in a wide variety of dosage forms, including injection, Spansule® sustained release capsules, suppositories, syrup and tablets.

For prescribing information, please see *PDR* or SK&F literature.

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Now! Obtain patient cooperation by...

taking the deprivation out of dieting!

Even 700 calories per day lets patients enjoy delicious meals with MOTT'S FIGURE CONTROL FOODS!

Here is a new kind of diet you can offer patients—familiar, tasty foods of excellent quality, for meals that are a pleasure to eat, yet low in calories, fat and carbohydrates.

The 60 Mott's Figure Control Brand Foods were developed to fit the most broadly-accepted and proven diet concept. They offer a prudent diet, reduced in calories an average of 50%, mostly through the reduction of hard fats (the saturated type), and carbohydrates. A patented non-caloric sweetener is used in the extra-fine quality fruits and desserts, providing satisfying sweetness without extra calories. Natural fruit sugars remain intact.

Patients on low-cholesterol diets may now enjoy low-fat beef dishes, ready to heat and eat. Where additional polyunsaturates are indicated, you may wish to suggest adding polyunsaturated oils to the sauces. Those patients who need drastic calorie reduction in carbohydrates will find it in Figure Control Fruits, Juices, Preserves and Desserts.

Calorie counts as well as carbohydrate, protein and fat proportions of each product appear on its Figure Control label. The wide variety of Figure Control Foods at local supermarkets makes meal planning easy for patients.

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HERE ARE TYPICAL 700 CALORIE PER DAY MENUS

BREAKFAST: Figure Control Breakfast Drink, high in Vitamin C, Farina with Figure Control Preserves or Maplette Syrup, Coffee with Figure Control Sweetener.
Calories—**about 95.** "Regular" food calories would be **about 235.**

LUNCH: Figure Control Fruits with Cottage Cheese, Figure Control French Dressing **or**
Figure Control Chopped Chicken Livers on Rye Bread Slice with Cole Slaw, Figure Control Whipped Dressing.
Black coffee or tea with Figure Control Sweetener.
Calories—**about 220.** "Regular" food calories—**about 400-600.**

DINNER: Shrimp in Figure Control Spaghetti Sauce, Figure Control Chicken a la King **or** Figure Control Braised Beef and Vegetables. Salad with Figure Control Italian Dressing, Figure Control Pears with Figure Control Chocolate Topping. Black coffee or tea with Figure Control Sweetener.
Calories—**about 350.** "Regular" food calories would be **about 720.**

NOTE: For more gradual weight loss, reduce calories daily by substituting two or more Figure Control Foods for "regular" foods in menus.

For your free jar of Figure Control Foods plus easy menu guidance for patients use this handy order form:

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Please send free jar of Figure Control Foods together with _____ free copies of Your Weight Control Plan.

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Each tablet (or capsule) contains 16 mg. phenobarbital blended with 65 mg. Bensulfoid®. The Bensulfoid is an inert diluent present to permit slow absorption of the phenobarbital. The usual dosage is one tablet or capsule after meals and at bedtime. Solfoton is especially adapted to prolonged use because of its virtual freedom from depression and other side effects. Contra-indications: identical to those of ¼ gr. phenobarbital.

REFER TO PDR

Poythress, White Section, Page 808 (1963 edition) and Product Identification Section

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Manufacturers of ethical pharmaceuticals since 1856

Suggests Many Reasons For Health Museum

"Courageous leadership and devotion to the goal of better health for more people will help the Michigan Health Council toward its new goal of a Michigan Health Museum."

So stated Bruno Gebhard, M.D., director of the Cleveland Health Museum, in his speech to the Michigan Health Council Annual Meeting.

Dr. Gebhard suggested the following advantages of a Health Museum:

1. Museums are places where people can see what up to now they have only heard or read about.

2. Museums represent material which is based on science without any bias.

3. Museums give permanency and continuity to all kinds of health education.

4. Visual methods are time-savers, both for the teacher and the student.

5. Museums not only satisfy but also stimulate the natural curiosity in health and related fields.

6. Museums are a good recruiting place for all types of health careers.

7. Seeing is easier and more convincing than reading or hearing.

8. Seeing is not only believing, but also relieving. We are afraid mostly of those things we do not understand.

Dr. Gebhard made the following comments about the establishment and development of health museums:

Museums of all kinds are often the outgrowth of world fairs and exhibitions. . . . Museums can be started out on a small scale similar to the one-room school house. . . . A couple of rooms in a hospital or health center might be the beginning. . . . Museums are usually the creation of an individual or a small group of men and women. . . . Museums seldom come into existence by committee appointment. . . . A museum should start with a small group of people who have power to act and can influence public opinion.



The most significant advance in analgesics since the isolation of morphine in 1805

Remarkable effectiveness and greater freedom from side reactions in the widest range of clinical applications

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clinically tested for 5 years/evaluated in 120 U. S. hospitals/over a quarter of a million doses given/ more than 25,000 patients treated

SUPPLIED:

Vials: 10 cc., singly and in boxes of three.
Ampuls: 1 cc. and 2 cc., in boxes of 12 and 100.
(Each cc. of NUMORPHAN* contains 1.5 mg. oxymorphone as the hydrochloride.)
Suppositories: 2 mg. and 5 mg., in boxes of 6.

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SAGINAW ASSISTANTS HONORED

Mrs. June Hawkins, president of the Saginaw County Medical Assistants Society, accepted a trophy at the 1962 Michigan State Medical Assistants Society meeting from Glenn E. Millard, M.D., chairman of the MSMAS Advisory Board. The award was for the greatest membership increase last year.

O. D. Stryker, M.D., Leads State Cancer Foundation

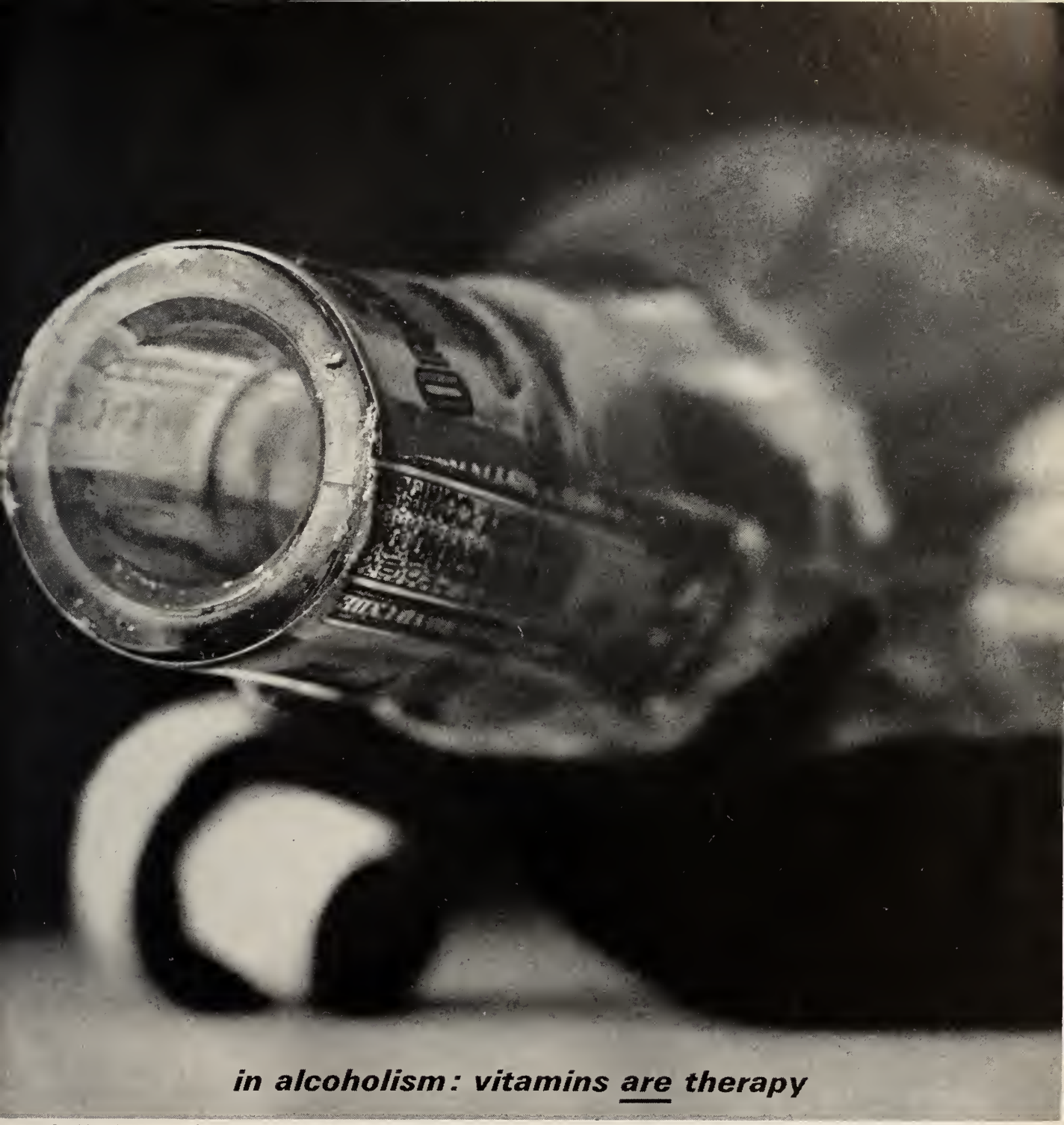
Oscar D. Stryker, M.D., Mt. Clemens, will serve this year as president of the Michigan Cancer Foundation, succeeding Rosser L. Mainwaring, M.D., Dearborn. Also elected at the recent annual meeting were Brock E. Brush, M.D., Detroit, vice president; and James C. Cook, M.D., Detroit, secretary. Michael J. Brennan, M.D., Detroit, and John H. McLaughlin, M.D., Birmingham, were newly elected to the board, and among those re-elected to the board were William Bromme, M.D., Detroit; Milton A. Darling, M.D., Detroit; James E. Lofstrom, M.D., Detroit; Glenn W. Bylsma, M.D., Pontiac; Daniel L. Rousseau, M.D., Mt. Clemens; Clarence H. Schultz, M.D., Dearborn; and Walter A. Stryker, M.D., Wyandotte.

Begin U-M '38 Fund

The University of Michigan Medical School Class of 1938 has established the "Class of 1938 Medical Fund" for use by the Dean of the Medical School as a direct benefit to medical students.

A check for $3,700, initiating the fund, was presented to Dean William N. Hubbard, Jr., M.D., during the recent 8th Triennial Medical Center Alumni Conference.

(Turn to Page 214)



in alcoholism: vitamins are therapy

A full "comeback" for the alcoholic is partly dependent on nutritional balance...aided by therapeutic allowances of B and C vitamins. Typically, the alcoholic patient is seriously undernourished...from long-standing dietary inadequacy, from depletion of basic reserves of water-soluble vitamins. Supplied in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

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WSU to Start Pharmacy Hall

Construction will begin April 1, for the new Shapero Hall of Pharmacy, honoring Nate S. Shapero, chairman of the board of Cunningham Drug Stores, at Wayne State University. The hall will cost $1,300,000 with $625,000 from the State of Michigan while the balance has been raised through gifts and grants from individual pharmacists, pharmaceutical associations and firms.

Architects for Shapero Hall of Pharmacy are Paulsen, Gardner and Associates of Bloomfield Hills.

MSMAS Seminar Set for March 14

A theme of "Challenges to the Medical Assistant" is expected to bring approximately 300 members of the Michigan State Medical Assistants Society to Detroit, March 14, for the 6th Annual Educational Seminar. Meeting will be held at the Detroit Leland Hotel.

A panel discussion of the "Role of the Laboratory in Clinical Diagnosis" will be moderated by Lyle E. Heavner, M.D., Detroit. Panelists include laboratory, x-ray and cytology technicians.

The annual L. Fernald Foster Memorial Lecture will be presented by Herbert J. Bloom, DDS, on material from his experiences as a dentist for two years aboard the *S.S. Hope.*

"Legal Considerations for the Medical Assistant" will be the topic of an address by Jeptha Schureman, Detroit attorney, whose firm specializes in malpractice defense.

Co-chairmen for the seminar are Misses Marlouise Redman and Mary Jayne Baker of Detroit. Reservations may be made by contacting Miss Elizabeth Kotsch, 1217 David Whitney Building, Detroit 26, Michigan.

Guide Printed for School Tuberculin Testing Project

The Michigan Tuberculosis and Respiratory Disease Association has published a new booklet, "Recommendations for Tuberculin Testing in Schools." The booklet sets up guide lines to standardize tuberculosis testing programs in Michigan schools.

The suggested program calls for skin-testing of all pupils in schools where this has not been done in previous years to be followed annually with tests of pupils on a rotating basis.

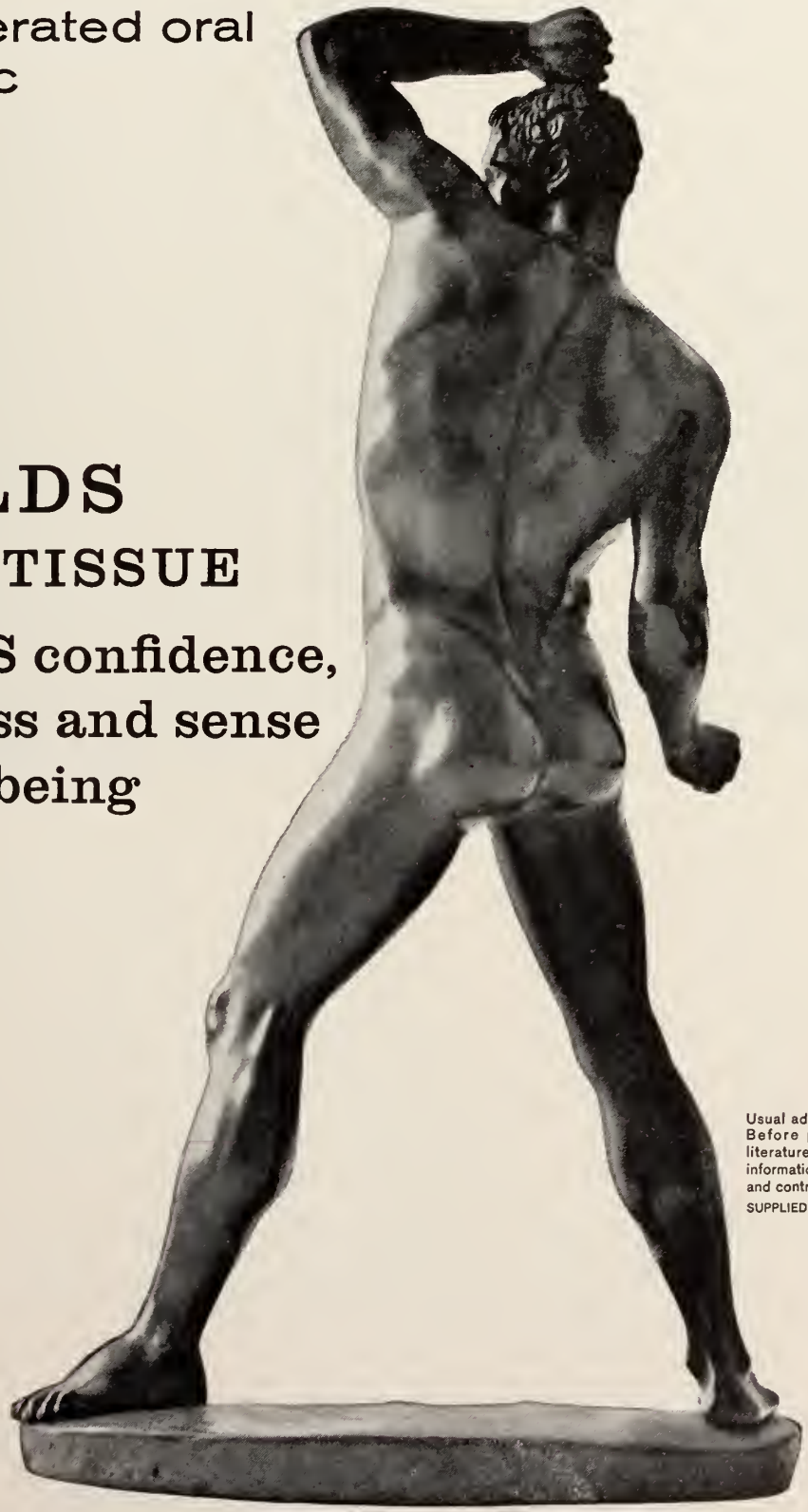
Major objective of the program would be to identify the estimated 26,000 Michigan school children believed to be infected and thus develop a control program leading to eradication of the disease.

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WINSTROL®

BRAND OF STANOZOLOL

well tolerated oral anabolic



BUILDS BODY TISSUE

BUILDS confidence, alertness and sense of well-being

Usual adult dose: 1 tablet t.i.d. Before prescribing, consult literature for additional dosage information, possible side effects and contraindications.

SUPPLIED: 2 mg. tablets. Bottles of 100.

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With WINSTROL, patients look better...feel stronger—because they are stronger



Meet the Airstream Land Yacht, a personal highway cruiser that makes real travel adventure easy and practical for the busy doctor. Outfitted to the smallest luxurious detail, your Airstream is always on "stand by"—ready for limitless road voyaging. You tow the Land Yacht lightly behind your car and follow your travel whims wherever they urge you to go—over sun-blessed mountain trails, through beckoning woods, roads to hidden lakes, up to Alaska for bear and big horn, down to Mexico for tarpon or jaguar, over to Europe for gaiety and sophistication... outside sources of water, light, power, and even sewage disposals, have no bearing on where you "drop anchor" for the night, for the week, or the month. A pressure system supplies water for drinking, cooking, bathing... electric power for lighting, heating and refrigeration with butane.

Land Yachting means real travel independence—no time-tables, tickets, packing; no bell-hops, doormen, tips; no highway food, unworkable plumbing, lumpy or saggy beds. Yes, Land Yachting is an exciting way to travel, here or anywhere in the world.

Write for free booklet "World At Your Doorstep"

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275 CHURCH STREET, JACKSON CENTER, OHIO

Say you saw it in the Journal of the Michigan State Medical Society

Question About Autopsy

Dear Doctor:

Your letter requesting an opinion with respect to the sufficiency of a consent to performance of an autopsy given by telegram or by monitored telephone conversation has been referred to me for reply.

Your letter indicated that you are familiar with the Michigan statute (Section 14.524 M.S.A.) requiring "written consent" to the performance of an autopsy.

Although I am unable to find that the courts of Michigan have ever had occasion to pass upon the precise question suggested by you, I am of the opinion that a consent by telegram would be a sufficient consent to comply with the statute if actually given by the person required by the statute to give consent. It must be recognized that there is always a slight element of danger in acting upon telegraphic consents since it would be relatively easy for an unauthorized person to send such a telegram. In relation, however, to the performance of an autopsy, it would be extremely unlikely that this would occur and I believe, therefore, as a practical matter there would be relative safety in acting upon telegraphic consents.

I could not reach the same conclusion, however, with respect to consents given by telephone even though the conversation were monitored. The statute is specific in requiring "written consent" and I do not believe that a telephone conversation even though proved to have taken place would be sufficient.

* * *

Consent for Surgery

Dear Doctor:

I have your inquiry with respect to the age at which a patient may give valid consent for anesthesia or surgery. Unfortunately, no iron-clad rule is laid down by a statute and there is therefore some area of uncertainty under some circumstances.

In the case of the unmarried minor, the general rule is that an operation requires the consent of the parent or guardian except in an emergency when immediate treatment is imperative and delay involves serious risk to the patient. Except in cases of real emergency, parent or guardian consent should be obtained wherever possible in all cases involving minors and where the patient is upwards of 15 years of age, the consent of the patient should also be obtained.

In the case of the minor patient who is married, consent of the patient and of the spouse should be obtained. Ordinarily, in the case of the married minor patient, consent of the patient and of the spouse will suffice but even in such circumstances safe procedure would indicate the advisability of obtaining parental or guardian consent also if reasonably possible. This is highly advisable particularly in cases involving radical procedures such as amputations or extraordinarily hazardous procedures.

I am sorry that I cannot give you more definite guidelines but in the absence of a specific statute, courts have a tendency to conflict in their rulings depending upon the circumstances of a particular case.

LESTER P. DODD,
Legal Counsel



...WITH 'METHEDRINE' SHE CAN HAPPILY REFUSE!



Controls food craving, keeps the reducer happy — In obesity, "our drug of choice has been methedrine . . . because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent." Douglas, H. S.: West.J.Surg. 59:238 (May) 1951.

'METHEDRINE'®

brand Methamphetamine Hydrochloride

Supplied: Tablets 5 mg., scored. Bottles of 100 and 1000.

Literature available on request.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

Brief and to the Point

HONORED—Saginaw has enlarged and remodeled a branch library and then named it the Archer A. Claytor Branch Library to honor Doctor Claytor. Doctor Claytor is a former MSMS "Foremost Family Physician of Michigan."

* * *

CITED BY CAMP—Camp Blodgett, a Grand Rapids area camp for underprivileged children, presented a scroll recently to David B. Hagerman, M.D., for long service to the camp. He was cited when he retired from the camp board of directors after 30 years of service.

* * *

LANSING M.D.'S HONORED—The 50th Anniversary banquet for the Sparrow Hospital featured awards to Earl I. Carr, M.D., who has served on the medical staff since its beginning, and to Fred Drolett, M.D., who delivered the first baby there. Doctor Drolett is the oldest doctor on the hospital staff.

* * *

FETED BY C C—C. E. Boone, M.D., was presented a clock by the Zeeland Chamber of Commerce "for 51 years of service to the community." The award was made at the Chamber's Annual meeting.

* * *

HONORED—A Certificate of Merit from the Michigan Health Officers Association was presented to Otto K. Engelke, Ann Arbor, before the Board of Supervisors of Washtenaw County.

* * *

COMMUNITY LEADER—Ralph M. Burke, M.D., Grosse Pointe, is serving as the new president of the Grosse Point Rotary Club.

* * *

RE-ELECTED—Lynn A. Ferguson, M.D., Grand Rapids, was renamed secretary-general of the American College of Gastroenterology, at its recent annual meeting in Chicago. Edward J. Krol, M.D., Chicago, is the new president.

* * *

SPEAKER—Mark Hruska, M.D., Pontiac, spoke about "Psychiatric Problems in Everyday Living" at the annual meeting of the Ukranian Medical Association in America held recently in Detroit.

* * *

BACK HOME—Richard C. Deming, M.D., is back home in Jackson after five weeks in Nigeria where he helped establish an orthopedic hospital. "Doctor Deming," according to the *Jackson Citizen-Patriot*, "saw a need for such facilities, volunteered to help, and paid his own way."

* * *

CONTINUES RESEARCH—Herman Pinkus, M.D., Monroe, recently received a $23,722 grant from the National Institute of Health to continue research on "Skin Structure Relative to Growth and Regeneration."



GUEST LECTURE—Jerome W. Conn, M.D., Ann Arbor, presented the "Pincoffs Lecture in Medicine" at the University of Maryland. The lecture honored Maurice Pincoffs, M.D., formerly of the University of Maryland School of Medicine. Dr. Conn spoke on "Primary Aldosteronism," a disease he discovered in 1955, and first published in JMSMS.

* * *

CITED—The Macomb County Board of Supervisors meeting in January highlighted the presentation of a Certificate of Merit to O. D. Stryker, M.D., Mt. Clemens, by the Michigan Health Officers Association.

* * *

HONORED BY MSU—Frederick Swartz, M.D., Lansing, was presented an Honorary Alumnus Citation recently for his accomplishment in medicine and geriatrics.

* * *

NAS-NRC APPOINTMENTS—Walter J. Nungester, M.D., Ann Arbor, has been appointed to membership in the Division of Medical Sciences of the National Academy of Sciences—National Research Council.

Thomas Francis, Jr., M.D., Ann Arbor, has been named to the executive committee of the Division of Medical Sciences. Another member of the Division is Ralph W. Gerard, M.D., Ann Arbor.

HONORED BY SURGEONS—Five Michigan doctors were honored at the 1962 International College of Surgeons Congress in New York. Elected to Fellowship (but did not attend the convocation) were Frank A. King, Jr., M.D., Benton Harbor, Frank H. Purcell, M.D., Detroit. Elected or advanced (and who did attend were Sidney Walker, M.D., Fellow, Port Huron; William M. Bremer, M.D., Associate, Detroit; and Clarence A. Synder, M.D., Junior Member, Grand Rapids.

* * *

WAYNE COURSES—Wayne State University College of Medicine will offer 48 special courses extending through the first quarter, January 7, until March 23.

* * *

HONOR HOPE FOUNDER—Two of the highest awards bestowed by the Government of Peru have been conferred upon William B. Walsh, M.D., Washington, D. C., physician, of Project HOPE. These honors have come to Dr. Walsh in recognition of the health and teaching work which he, both personally and through Project HOPE, has undertaken in Peru.

* * *

CITED—A Certificate for 20 years of service has been given by the Selective Service Board to Raymond S. Van Bree, M.D., Grand Rapids.



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COUNTY DIRECTOR—Byron B. Brown, M.D., Charlotte, is the new Health Director of Barry County and Eaton County Health Departments. He has practiced in Charlotte since 1935.

* * *

APPOINTED—M. K. Newman, M.D., Detroit, has been appointed co-chairman of the Section of Physical Medicine and Rehabilitation of the Pan-American Medical Association.

* * *

CITED—Two Lansing doctors were honored by the Selective Service Board for 20 years of service. Receiving certificates were T. A. Lucas, M.D., and C. F. DeVries, M.D.

* * *

NMC GRANT—Approval has been granted by State Board of Control for Vocational Education to Northern Michigan College for training of practical nurses at Chippewa War Memorial Hospital in Sault Ste. Marie, with use of funds made available under the Manpower Development and Training Act. The first class of twenty-five students was to be admitted this month.

* * *

JOINS ASHP—Don E. Francke, new director of the Department of Scientific Services of the American Society of Hospital Pharmacists, formerly was director of pharmacy service at University of Michigan Medical Center. He also was responsible for the hospital pharmacy internship program at Michigan, and was an associate professor in the College of Pharmacy.

* * *

GETS AWARD—William C. Behen, M.D., Lansing, is proud of an award from his school, Medico-Chirurgical College of Philadelphia. He was cited by the College's Medical Alumni Association for leadership in otolaryngology.

* * *

CHILDREN'S HOSPITAL DAY—The Children's Hospital of Michigan, Detroit, will hold its First Annual Cardiovascular Clinic Day, March 27, beginning at 2 p.m. at the Children's Hospital auditorium. The banquet and evening program will be at the Statler-Hilton Hotel. Guest discussants will be S. Gilbert Blount, Jr., M.D., Denver, and Dwight C. McGood, M.D., Rochester, Minn.

* * *

CANADIAN MEETING—Speakers from the University of Michigan and Wayne State University medical faculties will present the program for the Canadian-American Medical and Dental Ski Association's Third Annual Meeting at Mission Hill Lodge, Brimley, March 4-5-6. Speakers will include Robert D. Larson, M.D., and Loyal W. Jodar, M.D., both of Wayne; and Robert J. Bolt, M.D., and Norman W. Thompson, M.D., both of Ann Arbor.

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1. Pomeranze, J.: Clinical Med. 8:1155, June 1961. 2. Krall, L. P. and Bradley, R. F.: Geriatrics 17:337, May 1962. 3. DeLawter, D. E. et al.: J.A.M.A. 171:1786, Nov. 28, 1959. 4. Perkin, F. S.: J.A.M.A. 173:36, May 7, 1960. 5. Pearlman, W.: Phenformin Symposium, Houston, Feb. 1959. 6. Radding, R. S. et al.: Metabolism 11:404, April 1962. 7. Gold, A. et al.: Applied Therapeutics 2:137, 1960. 8. Brown, G. D. and Gabert, H.: Applied Therapeutics 4:451, May 1962. 9. Gold, A.: Applied Therapeutics 4:466, May 1962.

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IN MEMORIAM

CLARENCE B. FLANAGAN, M.D., 65, Menominee physician since 1932, died November 30, 1962.

A graduate of Chicago's Loyola University medical school in 1931, Doctor Flanagan interned at Mercy Hospital, Chicago, before coming to Menominee.

He was on the faculty of Jordan College and a member of the International College of Surgeons.

GEORGE C. HARDY, M.D., 78, practicing physician in Rochester for many years, died December 3, 1962.

A graduate of Wayne State University College of Medicine in 1907, Doctor Hardy was a Life Member of the Michigan State Medical Society.

ROY W. HODGES, M.D., 84, Mackinaw City physician for nine years, died December 7, 1962.

Doctor Hodges graduated from the Michigan College of Medicine and Surgery in 1907 and practiced in Detroit prior to moving to Mackinaw City.

He was a Life Member of the Michigan State Medical Society.

MILTON R. SCHMIDT, M.D., 60, Trenton physician since 1932, died December 13, 1962.

A graduate of the College of Medical Evangelists in California, Doctor Schmidt served his internship and residency at St. Mary's Hospital, Detroit, Wyandotte General Hospital and in Battle Creek. He was on the staffs of Wyandotte General Hospital, Oakwood, Outer Drive and Monroe Mercy Hospitals, as well as Seaway Hospital in Trenton, where he has been chief of staff since the facility opened two years ago.

He was a Fellow of the International College of Surgeons, the American Society of Abdominal Surgeons, the American Society of Geriatrics and a Diplomate of the American Board of Medical Examiners. Memberships included the Association of Military Surgeons and the World Medical Association.

WILLIAM H. TUTTLE, M.D., 57, nationally known Detroit chest surgeon, died December 22, 1962, in St. Louis, Missouri, where he was attending a meeting of the Western Surgical Association.

Doctor Tuttle was chief of staff at Herman Kiefer Hospital, chief of thoracic surgery at Kiefer and Harper Hospitals and a surgeon at Woman's Hospital. He also was consultant on thoracic surgery at Mt. Carmel Mercy and Jennings Hospitals and the Veterans Administration Hospitals.

Memberships included the American Surgical Association, American Association for Thoracic Surgery, and the Western Surgical Association. He received his medical degree from the University of Chicago in 1932. Doctor Tuttle was the first president of the Detroit Surgical Association.

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Michigan Authors

Boy Frame, M.D., Martin Fruchtman, M.D., Richmond W. Smith, Jr., M.D., Detroit, "Chronic Hypocalcemia in a Patient with Parathyroid Clear-Cell Hyperplasia," *The New England Journal of Medicine*, November 29, 1962.

C. L. Giles, M.D., G. L. Mason, M.D., I. F. Duff, M.D., J. A. McLean, M.D., Ann Arbor, "Cataract Formation and Systemic Corticosteroid Therapy," *Journal of the American Medical Association*, November 17, 1962.

Burton Silbert, M.D., Leo S. Figiel, M.D., Steven J. Figiel, M.D., Detroit, "Intramural Jejunal Hematoma Secondary to Anti-Coagulant Therapy," *The American Journal of Digestive Diseases*, October, 1962.

Leo S. Figiel, M.D., Steven J. Figiel, M.D., Fred K. Wietersen, M.D., "Is Surgical Removal of Every Colonic Polyp Necessary?", *American Journal of Roentgenology, Radium Therapy and Nuclear Medicine*, October, 1962.

R. H. Ramsey, M.D., H. E. Pedersen, M.D., Dearborn, "The Monteggia Fracture-Dislocation in Children," *Journal of the American Medical Association*, December 15, 1962.

E. S. Gurdjian, M.D., H. R. Lissner, M.S., L. M. Patrick, M.S., "Protection of the Head and Neck in Sports," *Journal of the American Medical Association*, November 3, 1962.

Meyer O. Cantor, M.D. Detroit, and **Jack E. Weiler,** Corning, N. Y., "Effect of Hydrogen Sulfide Upon Intestinal Decompression Tubes," *American Journal of Gastroenterology*, November, 1962.

Charles D. Hafner, M.D., Cincinnati, **John H. Wylie, Jr., M.D.,** and **Brock E. Brush, M.D.,** Detroit, "Esophageal Hiatus Hernia—Abdominal Approach," *Ohio State Medical Journal*, November, 1962.

William R. Eyler, M.D., Max D. Clark, M.D., James E. Garman, M.D., Roger L. Rian, M.D., and **Dan E. Meininger, M.D.,** Detroit, "Renal Artery Lesions in Patients With and Without Hypertension: A Comparative Study," *Lousiana State Medical Society*, November, 1962.

Robert E. L. Berry, M.D., Ann Arbor, "Limiting Factors of Graduate Training in Surgery," *Surgery, Gynecology and Obstetrics*, November, 1962.



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Editorial Comment

Practice vs Preaching

Lansing State Journal, October 16, 1962

Results of a quiet investigation at last year's convention of the American Medical Association disclose that doctors persist in neglecting their own health.

This despite a warning 20 years ago by the late Dr. Charles E. North who discovered this same phenomenon among those with whom he graduated from Columbia College of Physicians in 1900.

As a consequence of Dr. North's prodding, his remaining classmates began taking better care of their health. He himself headed a special longevity committee and was 92 when he died 15 months ago.

Crux of the doctor's health problem, Dr. North found, was that because doctors do not charge one another for professional services, they're reluctant to intrude on a colleague's valuable time.

Such reasoning, of course, overlooks the doctor's role in the community. His health is important to the well-being of his patients. His training and experience are valuable community assets, and he owes it to the community (if he won't admit owing it to himself) to see his doctor for regular checkups.

It's a case of practicing what he preaches.

Urges Special Care for Young Mother of Four or More

A survey of 20,000 births over a ten-year period indicates that the mother who has more than four babies—regardless of her youth—is just as likely to develop obstetrical problems as a "new" mother over 35 years of age.

S. J. Behrman, M.D., Ann Arbor, gave his report before a meeting of midwest district of The American College of Obstetricians and Gynecologists, in Indianapolis.

Doctor Behrman reported that complications became twice as frequent when the mother was over 35 years of age or when she already had four babies.

Among the complications for the baby, Doctor Behrman listed prematurity, asphyxia, fetal loss, and abnormalities.

He concluded, "the 26- or 27-year-old with her fifth or sixth pregnancy may present just as many problems, if not more, than the 35- or 40-year-old with her first pregnancy." The question of whether this should be a reason for family control was left for pro and con discussion by the medical audience.

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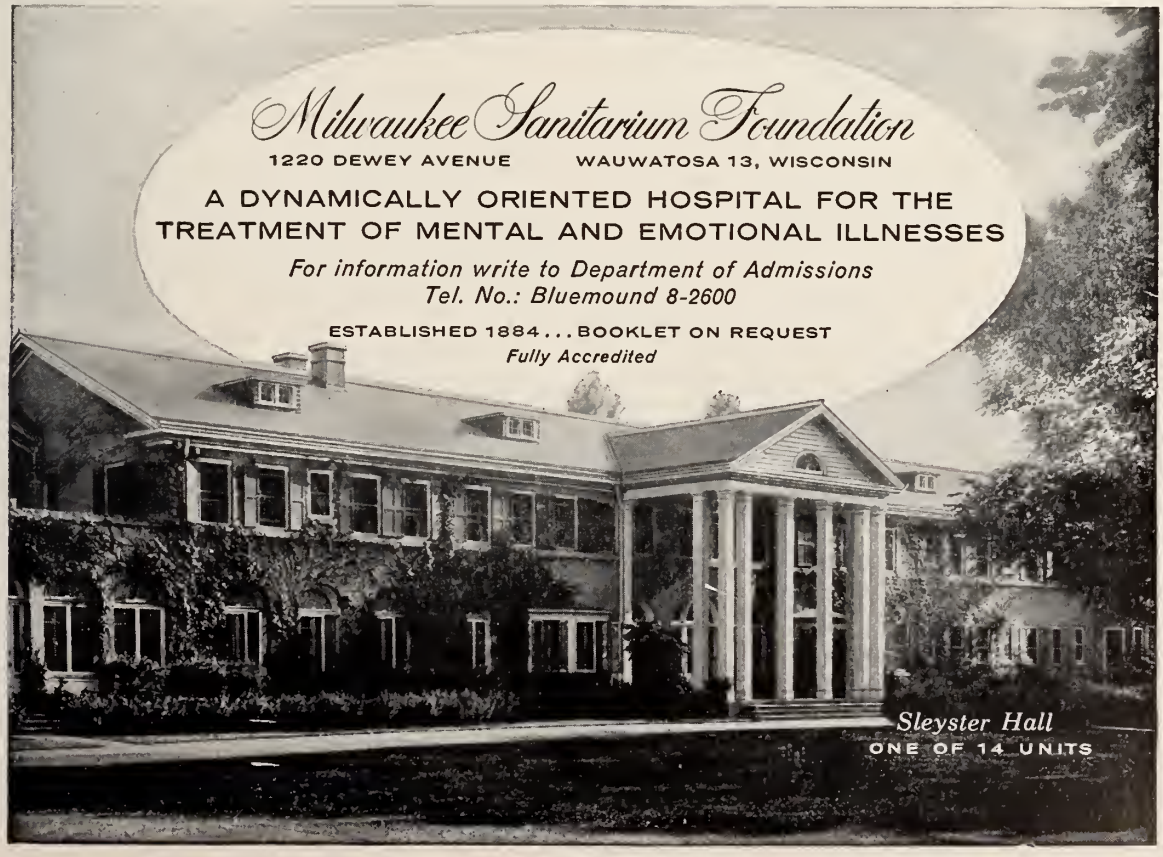
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Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

SURGERY—A CONCISE GUIDE TO CLINICAL PRACTICE. Edited by George L. Nardi, M.D., Assistant Clinical Professor of Surgery, Harvard Medical School; Associate Visiting Surgeon, Massachusetts General Hospital, and George D. Zuidema, M.D., Assistant Professor of Surgery, University of Michigan Medical School Staff Surgeon, University of Michigan Hospital. 23 authors. Foreword by Edward D. Churchill, M.D. Illustrations by Edith S. Tagrin. Boston: Little Brown and Company, 1961. Price, Paperback $8.50; Clothback $12.00.

In the constant evolution of concepts and refinement in surgical technique, it has become increasingly difficult to reduce the body of knowledge incorporated in the art and science of surgery to a volume practical to that group which holds interest in this area. A very pleasing effort in this regard has been made by Doctors Nardi and Zuidema, in a very large paperbound volume.

The text attempts to set forth the hard facts comprising the common body of knowledge which are drawn upon in forming judgments operative in common surgical practice. Present is a consideration, not only of general surgery *per se*, but a rather extensive documentary of thoracic and chest surgery, orthopedic, and gynecological surgery.

To prepare this work, 23 separate authors contributed in the area of their specialty and subspecialty. There are numerous illustrations, and bibliographies accompany each chapter. A well-developed chapter presents the relationship of surgery to the patient's emotional response. Discussed also is the legal obligation of the surgeon.

We, in Michigan, should be pleased that a large share of the effort of its creation belongs to Dr. George D. Zuidema, Assistant Professor of Surgery, University of Michigan, and staff surgeon at University of Michigan Hospital.

J.G.G.

PRACTICAL ANESTHESIOLOGY By Joseph F. Artusio, Jr., M.D., Professor of Anesthesiology in Surgery and Professor of Anesthesiology in Obstetrics and Gynecology, Cornell University Medical College, New York, N. Y.; Anesthesiologist in Chief, The New York Hospital-Cornell Medical Center, New York, N. Y., and Valentino D. B. Mazzia, M.D., Professor and Chairman of the Department of Anesthesia, New York University School of Medicine and Post Graduate Medical School, New York, N. Y. Visiting Physician in Charge of Anesthesia, Bellevue Hospital Center, and Attending and Director of Anesthesia, University Hospital, New York, N. Y.; Chief Consultant in Anesthesiology, Manhattan Veterans Administration Hospital, New York, N. Y. Illustrated. St. Louis: C. V. Mosby Company, 1962. Price, $7.75.

This book, as the author suggests, is written for the medical student, general practitioner and for the nurse anesthetist. It is a short and concise outline with simple explanations of the subjects involved in the administration of Anesthetics and suggests ways of treating certain conditions both before, during and after an anesthetic is given. It should be of value to the occasional surgeon or prospective surgeon and general practitioner in understanding anesthesia today and the reasons for certain treatment in the administration of anesthesia. This book, I am sure, was not intended as a textbook for the teaching of anesthesia and its administration, but only as an informational source for quick reference.

The author's treatment of elementary principles is excellent and is also a good reminder for all anesthetists as to the proper way of exercising their skills in a way that is most beneficial to the patient and in a reassuring degree to the attending physician and surgeon.

Many aspects of anesthesia are covered in short form as to the types of anesthetics, their administration, why they are administered in certain conditions, and also as to the use of accessory drugs before, during, and after administration of anesthetics. The author suggests caution for the novice many times and this, of course, cannot be overemphasized.

Kenneth C. Simmons, CRNA

CIBA FOUNDATION SYMPOSIUM ON TUMOR VIRUSES OF MURINE ORIGIN. Editors for the Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Maeve O'Connor, B.A. With 72 illustrations. Boston: Little, Brown and Company, 1962. Price, $10.75.

This volume comprises the proceedings of the many small conferences engendered by the Ciba Foundation. A highly technical collection of papers regarding the above-mentioned viruses, both as to type and characteristics is discussed. These are particularly discussed in view of their responsibility in the mechanism of carcinogenesis.

J.G.G.

BOOKS RECEIVED

SHOCK PATHOGENSIS AND THERAPY. An International Symposium, Stockholm, June 27-30, 1961. Sponsored by Ciba. Chairman U. S. von Euler, Stockholm. Edited by K. D. Bock, Basle. With 120 Figures. Berlin-Goettingen-Heidelberg: Springer-Verlag, 1962. Price, $13.00.

CURRENT DIAGNOSIS AND TREATMENT. By Henry Brainerd, M.D., Professor of Medicine and Chairman, Department of Medicine, University of California School of Medicine (San Francisco), and Physician-in-Chief, University of California Hospitals (San Francisco); Sheldon Margen, M.D., Research Biochemist, Department of Biochemistry, University of California School of Medicine (San Francisco); Milton J. Chatton, M.D., Assistant Clinical Professor of Medicine, University of California (San Francisco) and Stanford University (Palo Alto) Schools of Medicine, and Geriatric Consultant, Palo Alto Medical Clinic, and associate authors. Los Altos, California: Lange Medical Publications. 1962. Price, $8.50.

CIBA FOUNDATION SYMPOSIUM ON RENAL BIOPSY. Clinical and Pathological Significance. Editors for the Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Margaret P. Cameron, M.A. With 134 illustrations. Boston: Little, Brown and Company, 1962. Price, $10.50.

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BASIC ANXIETY. A New Psychobiological Concept. By Walter J. Garre, M.D. New York: Philosophical Library, 1962. Price, $5.00.

FINGER PRINTS, PALMS AND SOLES. An Introduction to Dermatoglyphics. By Harold Cummins, Ph.D., Professor of Anatomy and Assistant Dean, School of Medicine, Tulane University, and Charles Midlo, M.D., formerly Associate Professor of Microscopic Anatomy, Tulane University. New York: Dover Publications, Inc., 1962. Price, $1.95.

THE DYNASTY. A Medical Novel. By Charles H. Knickerbocker. Garden City, New York: Doubleday & Company, Inc., 1962.

DISSEMINATION OF CANCER. Prevention and Therapy. By Warren H. Cole, M.D., F.A.C.S., Professor and Head of the Department of Surgery, University of Illinois College of Medicine; Surgeon-in-Chief, Illinois Research and Educational Hospitals, Chicago; Gerald O. McDonald, M.S., M.D., F.A.C.S., Associate Professor of Surgery, University of Illinois College of Medicine; Attending Surgeon, West Side Veteran's Administration Hospital, Chicago; Associate Attending Surgeon, Illinois Research and Educational Hospitals, Chicago; Assistant Attending Surgeon, Presbyterian-St. Luke's Hospital, Chicago; Stuart S. Roberts, M.S., M.D., Instructor in Surgery, University of Illinois College of Medicine; Clinical Fellow, American Cancer Society, and Harry W. Southwock, M.D., F.A.C.S., Clinical Associate Professor of Surgery, University of Illinois College of Medicine; Associate Attending Surgeon and Director of the Tumor Clinic, Presbyterian-St. Luke's Hospital, Chicago; Attending Surgeon, St. Francis Hospital, Evanston, Illinois. New York: Appleton-Century-Crofts, Inc., 1962.

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February, 1963
Volume 62
Number 2A

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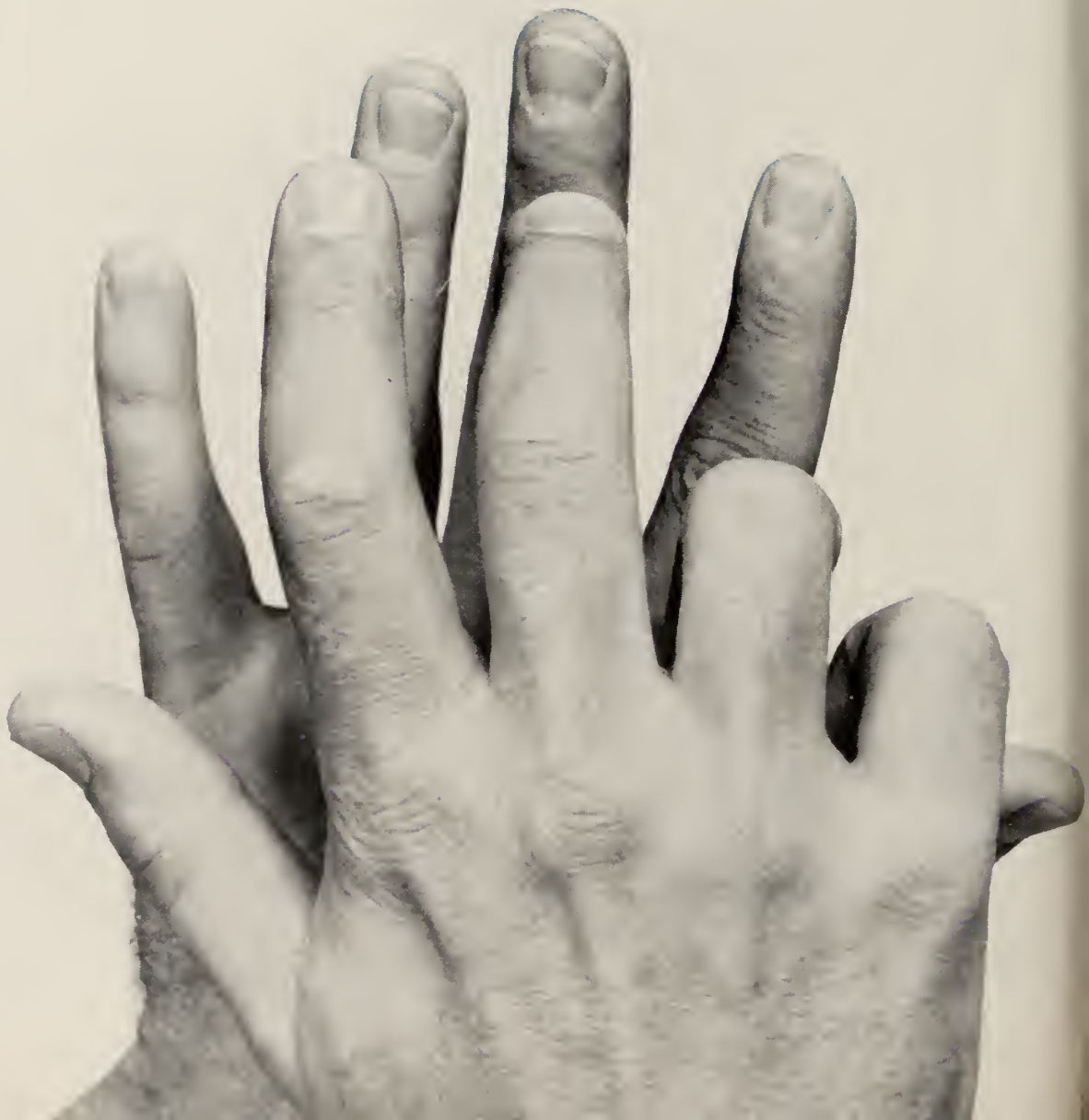
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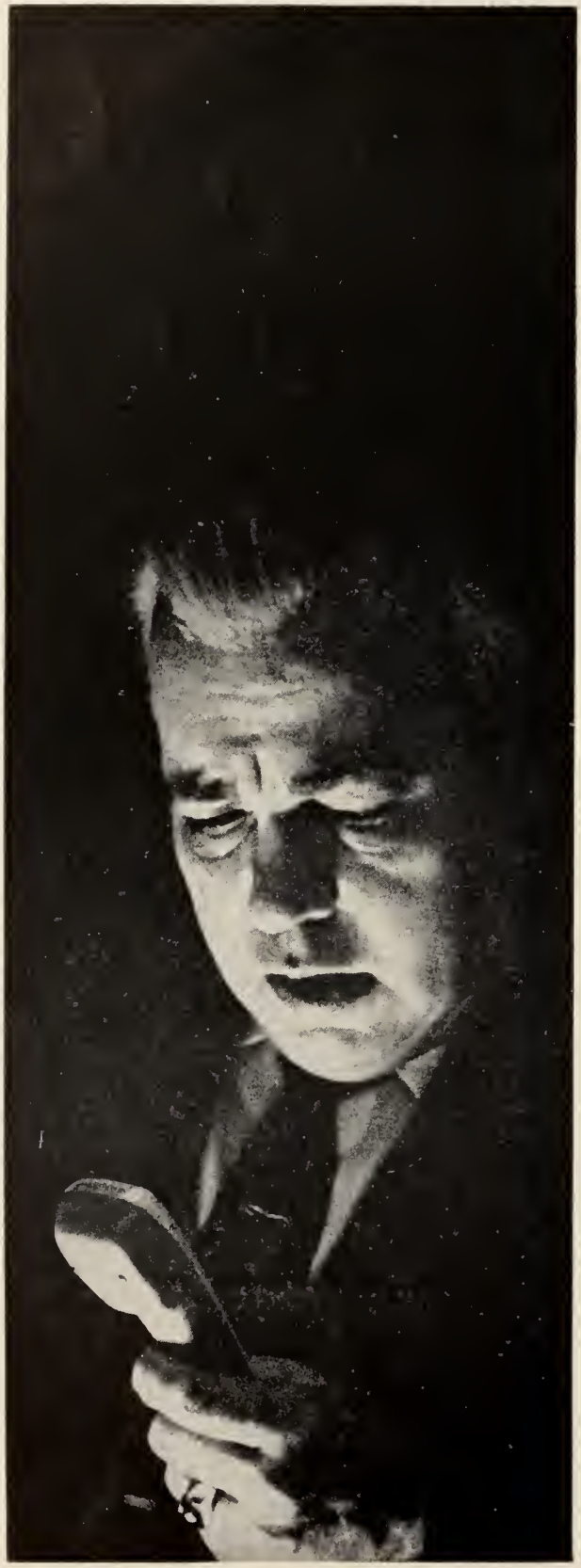
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Executive Director and Business Manager of THE JOURNAL
WM. J. BURNS, LL.B.
120 W. Saginaw Street, (Box 152)
East Lansing, Michigan.

All communications relative to exchanges, books for review, manuscripts, should be addressed to Wilfrid Haughey, M.D., 610 Post Bldg., Battle Creek, Michigan.

All communications regarding advertising and subscriptions should be addressed to Wm. J. Burns, 120 W. Saginaw Street, East Lansing, Michigan. Telephone 337-1351 (Area Code 517).

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THE COVER

The small cover sketch is always quickly identified as an orthopedic symbol. This number of THE JOURNAL contains several excellent articles about various aspects of orthopedics.

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President's Page

VOTE APRIL 1



Clarence D. Owen

President

Michigan State Medical Society

It was President Eisenhower who said "Politics ought to be the part-time profession of every citizen."

And all of us have that opportunity now to be concerned and active as the April 1st election nears.

A checklist on practical politics has been developed by the Chamber of Commerce of the United States suggesting 69 different activities that an individual can participate in.

One of these is the chance to "Exercise our 'X' " on Election Day. Certainly, we can all at least do that much as American Citizens. But many Americans even pass by that right—only 62 percent of the eligible voters cast their ballots in the 1960 Presidential election.

This April 1 election is indeed important to professional people, and to every Michigan resident. At stake is the new Constitution, and also the controlling offices in the fields of education and judiciary.

The MSMS Council has gone on record urging a "Yes" vote on the proposed new Constitution for Michigan. The new Constitution merits your vote and your support.

It will be adopted (or rejected) by a simple majority of those who get out to vote April 1.

One MSMS member is running for state office April 1—Alfred H. Whittaker, M.D., President-Elect of the Wayne County Medical Society. He was nominated by the Republican state convention for one of two seats on the Board of Governors of Wayne State University. We also will elect members to the University of Michigan Board of Regents, Michigan State University Board of Trustees, State Board of Education; we will select a State Superintendent of Public Instruction; and also two members of the Supreme Court of Michigan.

There are many ways you can participate now—before the election, and—on election day itself.

But, certainly *VOTE* on April 1.

MSMS Council Urges "Yes" Vote, April 1, On New Constitution



The Michigan State Medical Society, by action of the Council, has officially endorsed and urged adoption of the proposed new constitution for Michigan.

O. B. McGillicuddy, M.D., Chairman of The Council, in making the announcement after the annual meeting of The Council in January said that the action followed a thorough study of the provisions of the document.

"We believe that the people of Michigan will be able under this proposed document to maintain their essential freedoms and at the same time benefit from more efficient state governmental organization," Doctor McGillicuddy declared.

MSMS officials urge every doctor to vote for sure April 1 for adoption of the new constitution and to urge others to vote.

This will be the first opportunity for most Michigan doctors and residents to vote on the question: "Do you approve of a new State Constitution?" The last such election was in 1908. The voters that year accepted a revision of their former 1850 Constitution. The 1908 version, amended 66 times since then is the present Michigan Constitution.

Let's review events up to now: The people of Michigan voted in 1961 to hold a Constitutional Convention, the delegates were elected by the people and they met for the first time on October 3, 1961.

Extensive hearings on the various matters were held by 10 Con-Con Committees, which were bi-partisan. Research experts were available to assist the delegates. This first phase of the work was completed in December, 1961. The second phase was the presentation of committee reports to the total convention. Each proposal was considered three times by the convention assembly.

Although there were few unanimous votes among the delegates on any issue, 190 of the 250 sections had nearly unanimous approval. The entire document was approved by a better than 2-to-1 vote of the delegates.

The campaign to adopt the proposed Constitution is being sparked by Governor Romney. Many organizations have endorsed the document and several are conducting a campaign to defeat the measure.

MSMS Building Serves

A photo of the MSMS headquarters appears in the January *Newsletter* of the National Association of Exhibit Managers. The article, in part, points out that "Michigan doctors, through their new building, are seeking to improve their services not only to the medical profession but also to the general health of the public."

Elected President

William J. Burns, MSMS executive director, is the new president of the Professional Convention Management Association for 1963. He was elected at the annual convention January 2-5, 1963, in Hollywood, Florida, where he served as program chairman.

The PCMA has a membership of 100 men and women who manage professional conventions and exhibitions.

On National Program

Frederick C. Swartz, M.D., Lansing, Chairman of the AMA Committee on Aging, was a participant in the panel "Where Do We Stand Today" at the Third National Congress on Voluntary Health Insurance and Prepayment, in Chicago on February 15-16. Doctor Swartz spoke on "Coverage for the Aged."

Speaks in Wisconsin

MSMS President C. I. Owen was one of the featured speakers in February at the week-long workshop of the Wisconsin State Medical Society. He joined with the state medical society presidents from Illinois, Minnesota and Iowa in a discussion of "Medicine's Major Problems and Their Solutions."

Michigan Medical Meetings

Hospital Section, Michigan Library Association, April 15, Bronson Hospital, Kalamazoo.

Western Michigan Trauma Meeting, April 17, Hackley Art Gallery, Muskegon.

Harper Hospital Centennial, May 1-3, Detroit.

Wayne University Medical Alumni Clinic Day, May 8, Sheraton-Cadillac, Detroit.

Michigan Health Council State Conference May 21-22-23, Pantlind Hotel, Grand Rapids.

Michigan Kidney Disease Foundation—Second Annual Renal Disease Symposium, May 25 and 25, write John M. Sheldon, M.D., University Hospital, Ann Arbor.

Coller-Penberthy Clinic, July 26-26, Traverse City.

"MSMS Society Nights"

Allegan County, April 9, at Allegan Health Center, 7 p.m.

Barry County, April 15, Hastings.

Oakland County, April 3, at Kingsley Inn, Bloomfield Hills, 6:30 p.m.

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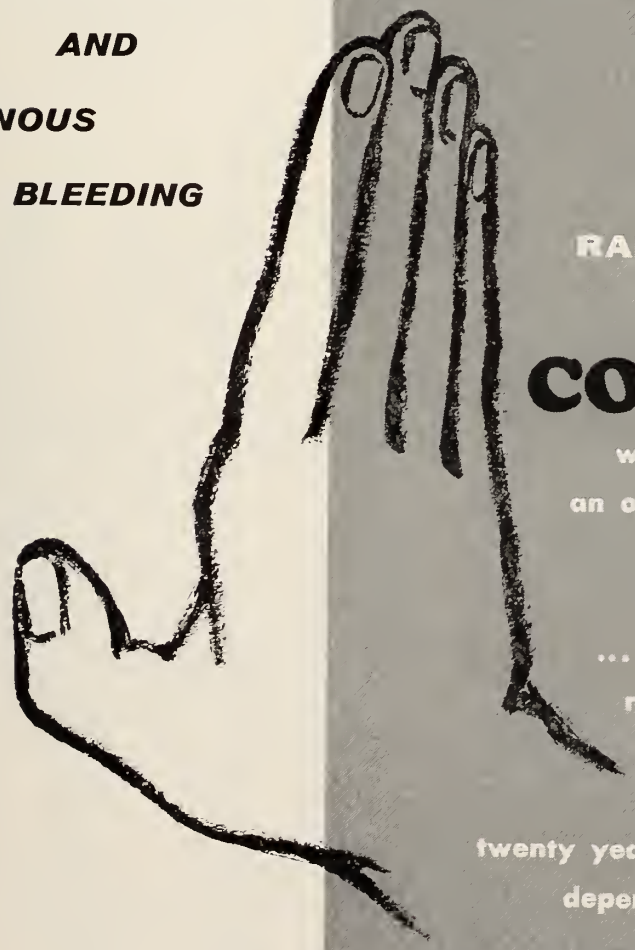
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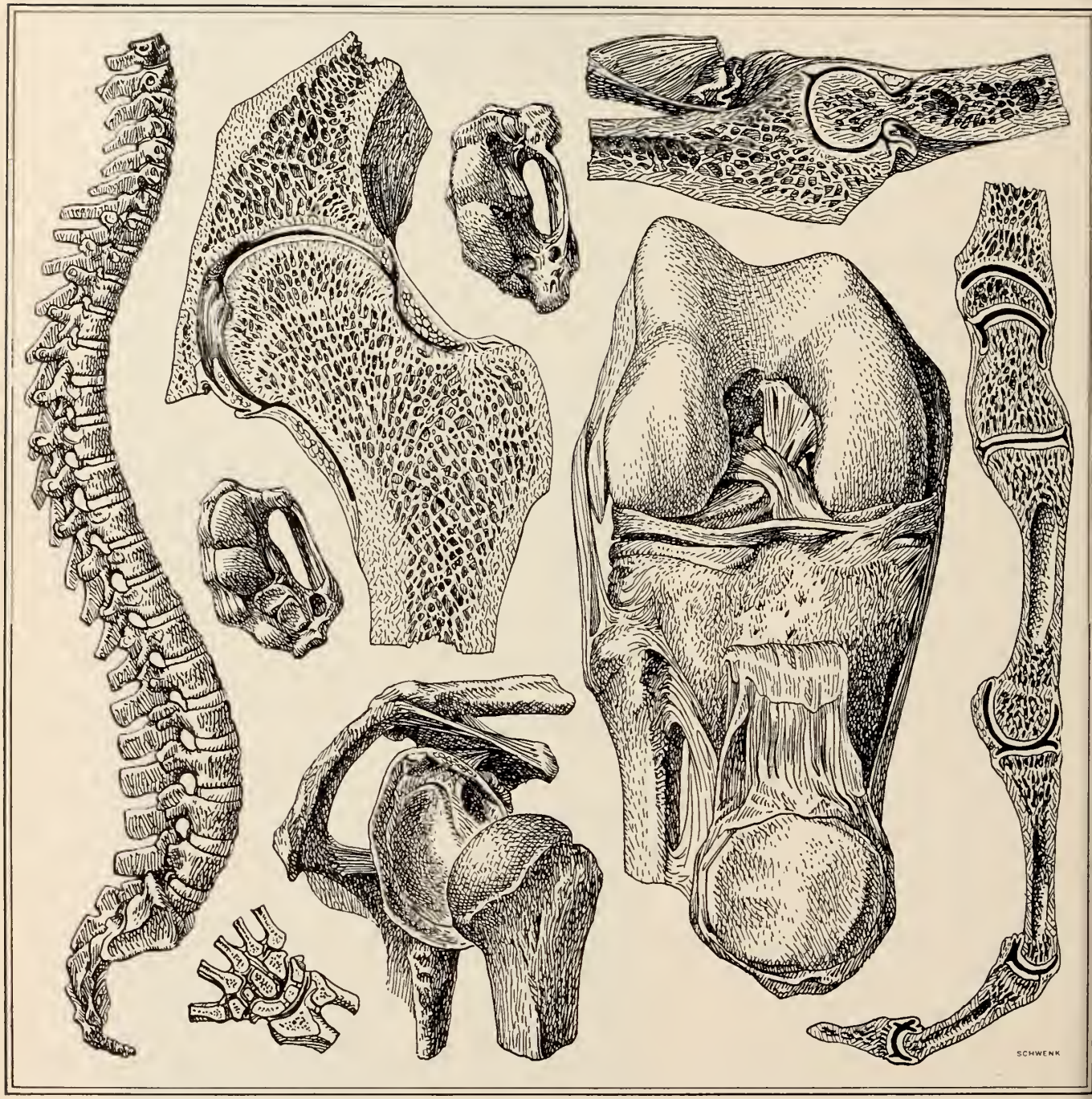


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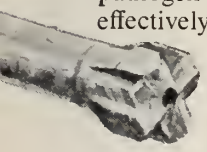
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Photo Highlights of MSMS Seminar

(See article on Page 261)



(Left) Six men received special citations from the Michigan State Medical Society at its Annual Awards Luncheon in Lansing. Left to right are Lawrence A. Drolett, M.D., Lansing; E. I. Carr, M.D., Lansing; William McNary, Detroit; Ralph Reed, Detroit; Leon A. Sweet, Ph.D., Detroit, and Luther R. Leader, M.D., Detroit.



(Right) Michigan doctors of medicine who are serving as presidents of national medical and health organizations received special awards at the Seminar from C. I. Owen, M.D., at left, MSMS President. Recipients were, left to right next to Doctor Owen, Harold F. Falls, M.D., Ann Arbor; Albert D. Reudemann, M.D., Detroit; Jerome W. Conn, M.D., Ann Arbor; M. Duane Sommerness, M.D., Traverse City, and Frederick C. Swartz, M.D., Lansing. Also honored was Max K. Newman, M.D., Detroit, shown in photo insert.



(Left) The morning Seminar panel speakers suggested "Responsibilities of Physicians in Community Affairs." Panel speakers were Carl R. Anderson, left, of Ypsilanti; Robert H. Albert, fourth from left, of Saginaw, and Arlon Ley, at far right, from Grand Rapids. Panelist D. Hale Brake, of Stanton, opened the program and left because of other business. The morning presiding chairman was R. W. Teed, M.D., Ann Arbor, third from left, and the panel moderator was O. J. Johnson, M.D., Bay City, second from left.



(Right) The afternoon Seminar panel on "Physicians Act to Meet Challenges in Community Affairs" was moderated by Robert J. Mason, M.D., Birmingham, at far right. Panelists were, left to right, Otto K. Engelke, M.D., Ann Arbor; Carl J. Sprunk, M.D., Melvindale; Everette Gustafson, M.D., Pontiac, and R. E. Anderson, M.D., Flint, with the afternoon presiding chairman, Howard T. Knobloch, M.D., Bay City, second from right. Panelists not shown in this photo were Louis F. Hayes, M.D., Gaylord, and John R. Rodger, M.D., Bellaire.

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Rational formula. And sweetened with sugar-free SUCARYL.

If they look good to you, imagine what youngsters will think.

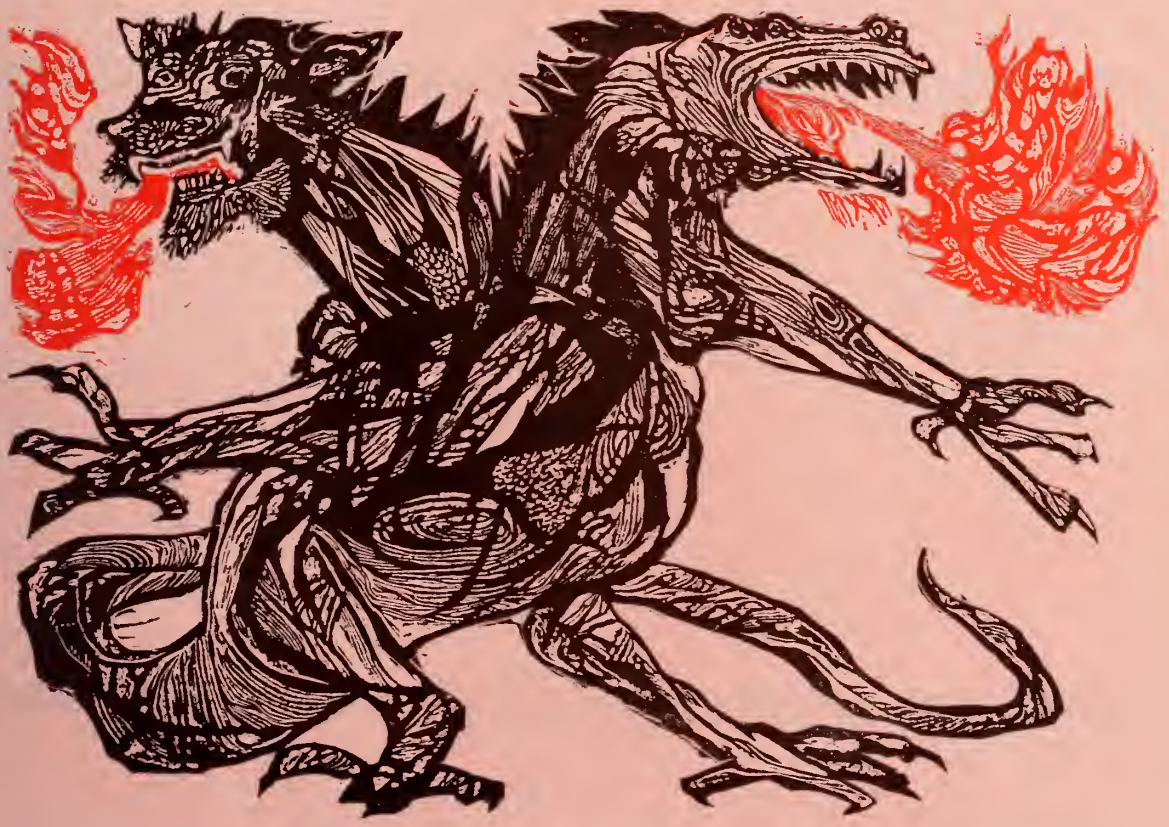
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MEDICAL SOCIETY
AUDITORIUM

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9:00 TO 12:00 A.M.
2:00 TO 5:00 P.M.

Luncheon

MAY 3, 1963

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Say you saw it in the Journal of the Michigan State Medical Society

Future Physicians Club Successful in Saginaw



The Saginaw County Medical Society continues to sponsor and be enthusiastic about its Future Physicians Club. An excellent progress report about the Club is provided by William G. Mason, M.D., Saginaw, for interested MSMS members and county societies to consider for their community. Doctor Mason reports:

"Approximately two years ago, we started a Future Physicians Club made up of all students interested in medicine, who were then in high school. The information concerning such clubs was made available to me from three sources. The first is the American Medical Association which sent me many brochures and talks and information on exhibits which could be obtained from them. A second source was from Evert Wood, M.D., Lovelace Clinic, 4800 Gibson Blvd., S.E., Albuquerque, New Mexico. The third source was the Essex County Medical Society, 120 Halsted, East Orange, New Jersey. The last two places have had future physicians clubs in operation since approximately 1957 and 1960 respectively.

"Our Club in Saginaw accepts any student interested in medicine from any high school in the country. This past year, the students requested that they be allowed to elect a president and vice-president, and a secretary. This they have done, and are now in complete charge of the meetings, which are planned one year ahead and include such subjects as a discussion by an intern and resident about their work and their schooling. This year, we made a tour of the Pediatric Ward at Saginaw General Hospital under the guidance of the resident physician, showing them all the aspects of medical care in the hospital. The third meeting was run by a psychiatrist, who talked about psychiatry in general and its specialty in medicine. In January, we went to the Malleable Iron Foundry and were entertained by General Motors and the Medical Staff there. In February, we will have a demonstration of EEG, and pace maker and defibrillator, impressing upon them the fact that there are many applications of electronics in medicine.

"In March, we have what we call a financial meeting to which the parents of these children are invited, to explain to them what it entails financially to put a person through medical school. Scholarships and grants are also discussed. In April, we plan to have a meeting at one of the hospitals with the pathologist who will demonstrate techniques showing them tissues and various specimens. There are plans to assign each senior to a doctor for a full day in the office and on rounds.

"In general, we feel that most of the students who come to these meetings will not become doctors, but if we can glean from this group a few who will go on into medicine, we feel that it has been a success. We have also found that the girl members are more

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than likely interested in nursing, but here again we feel that it will be of some help.

"All in all, the Saginaw County Medical Society has backed this organization, not only with ideas and enthusiasm, but financially."

Midland Society Supports Medical Examiner Election

Members of the Midland County Medical Society are eagerly looking forward to the April 1 election there on a special question of replacing the present coroner system with the medical examiner system.

The Midland Society members took an active role in circulating petitions to place the issue on the ballot. The petition approach was necessary because the Midland County Board of Supervisors did not take the initiative to place the question before the people.

The *Midland Daily News*, in an editorial in January, expressed the view that "the voters have the right to decide." The editorial also declared that "Midland County people will, we believe, vote for the more scientific medical examiner system if given an opportunity to make a decision." The editorial further stated: "Exact determination of the cause of death is becoming increasingly important. Pathologists' findings often determine whether a person died by his own hands, from a heart attack or disease, or by accident—facts which may involve large sums of money in workmen's compensation or insurance from policies that exclude suicide or pay double in case of accidental death."

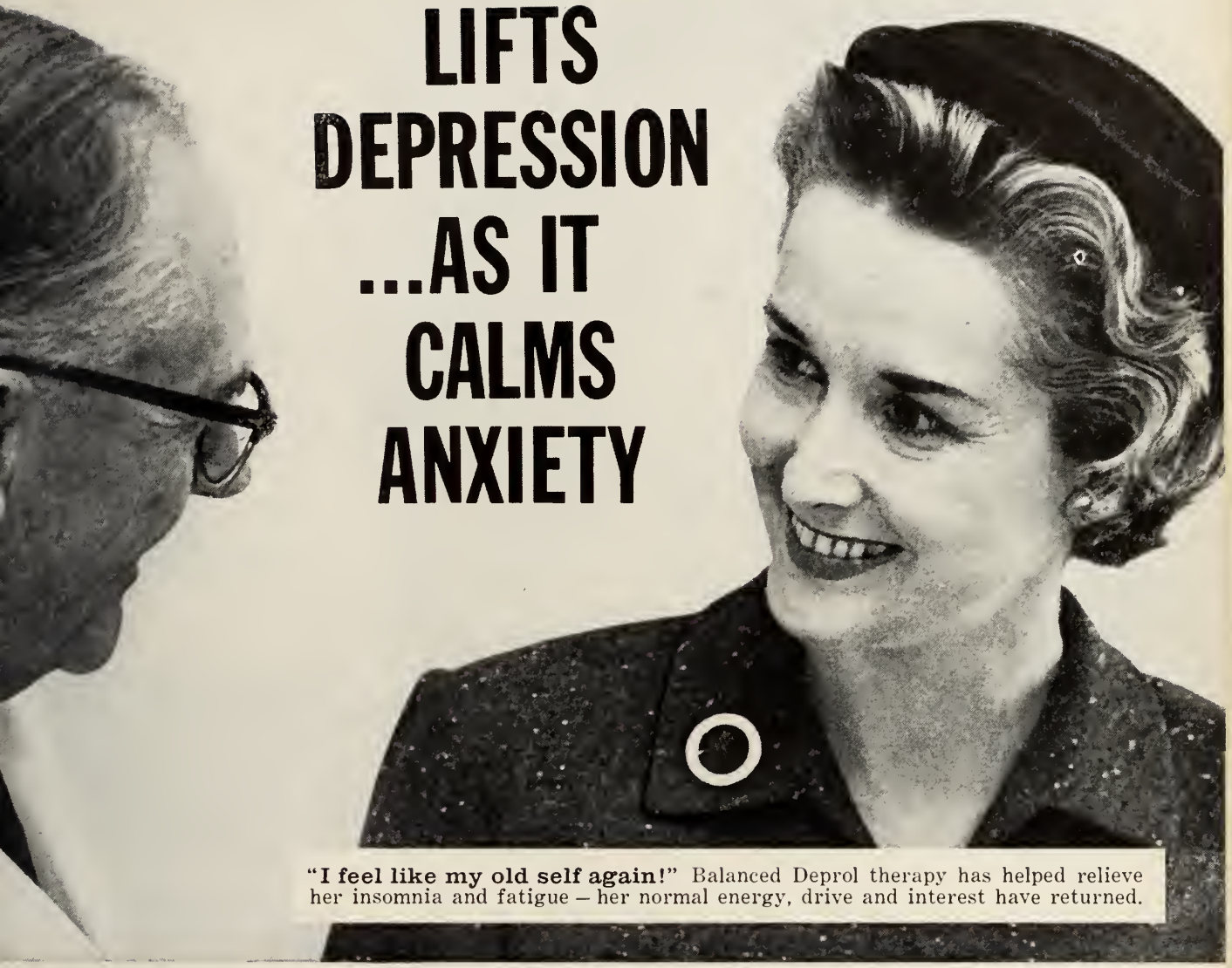
Police Thank Wayne Society

The Wayne County Medical Society recently received commendations from Detroit Police Commissioner George Edwards for helping in the chain of events which led to the arrest of a man who had been making indecent, threatening phone calls to the wives of doctors and other professional men in the Detroit area. Officials of the WCMS participated in the civic reception when two police officers received the *Detroit News* "Policeman of the Month" awards for their effective service in solving this case.

The Westchester County (N.Y.) Medical Society prints a little brochure, prepared by the Society, emphasizing that "for your health's sake each person should have a periodic check-up by his personal physician annually." The folder is distributed through doctors' waiting rooms and with doctors' statements. Such leaflets can point out that doctors are interested in disease prevention and that exams are good investments, keeping medical costs low by early diagnosis.

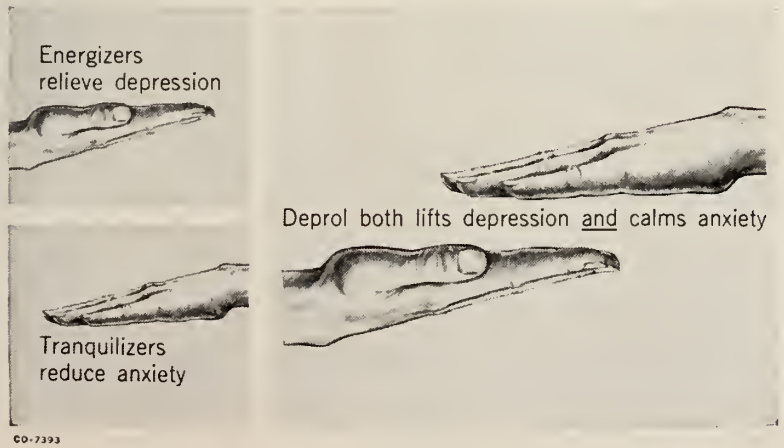
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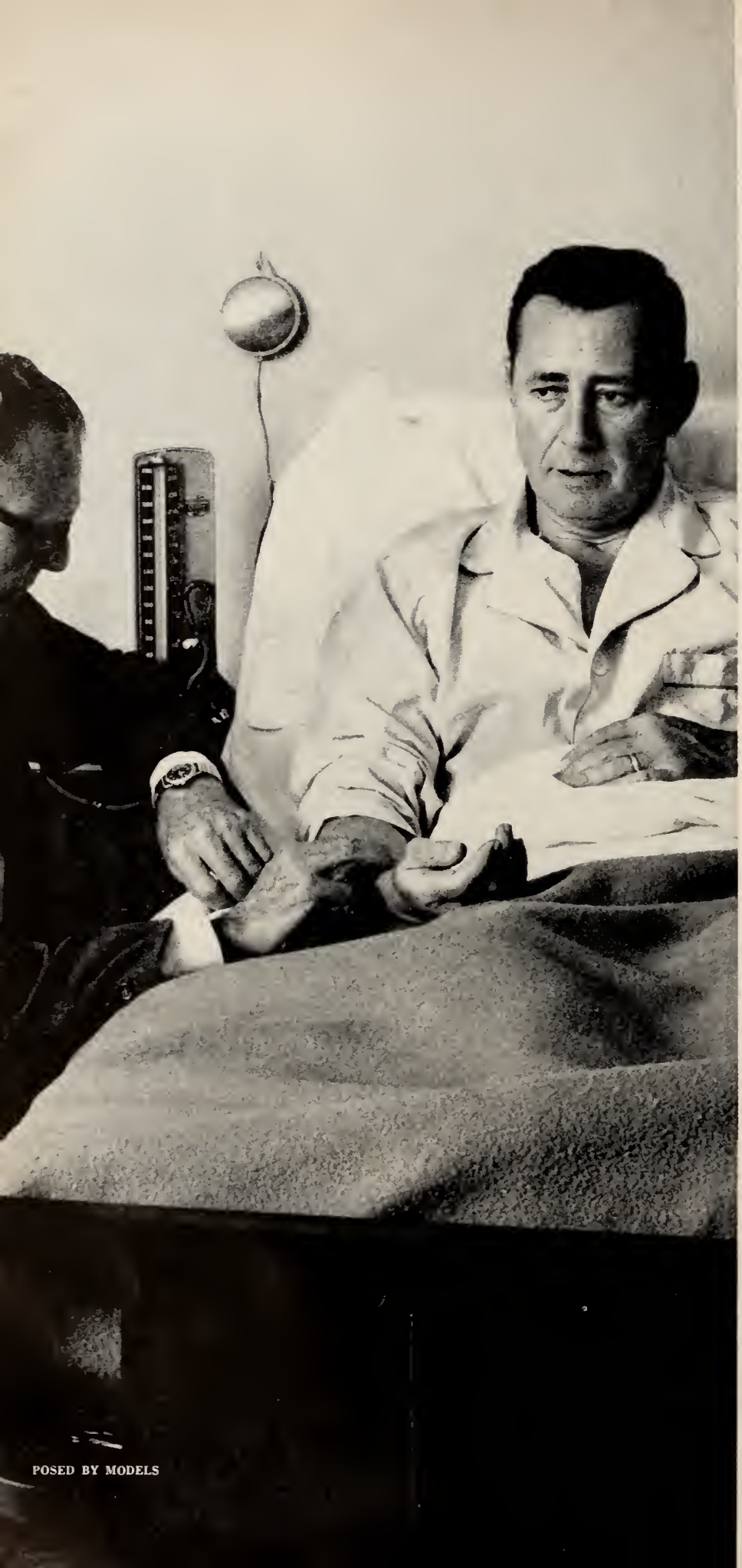
Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scored tablets.

Write for literature and samples.

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in bronchitis—Considering the pattern of mixed bacteria, localized or diffuse involvement, potential underlying disease, and the need to allay symptoms and ease respiratory/cardiac function...physicians often include DECLOMYCIN demethylchlortetracycline in the course of therapy.

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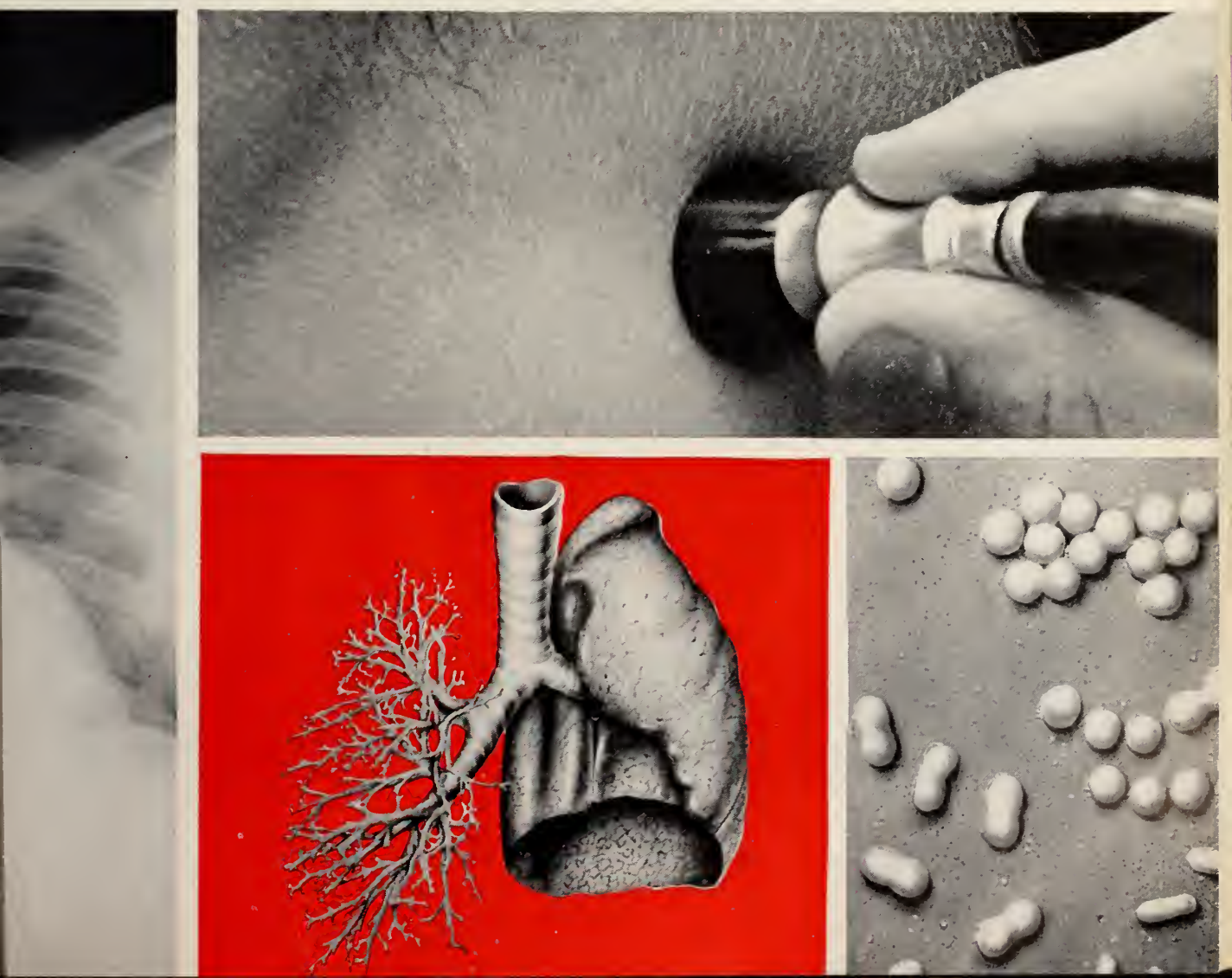
the decision is for

For *adults: Capsules,* 150 mg. and 75 mg. For *children:* cherry-flavored *Pediatric Drops,* 60 mg./cc., and cherry-flavored *Syrup,* 75 mg./5 cc. Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

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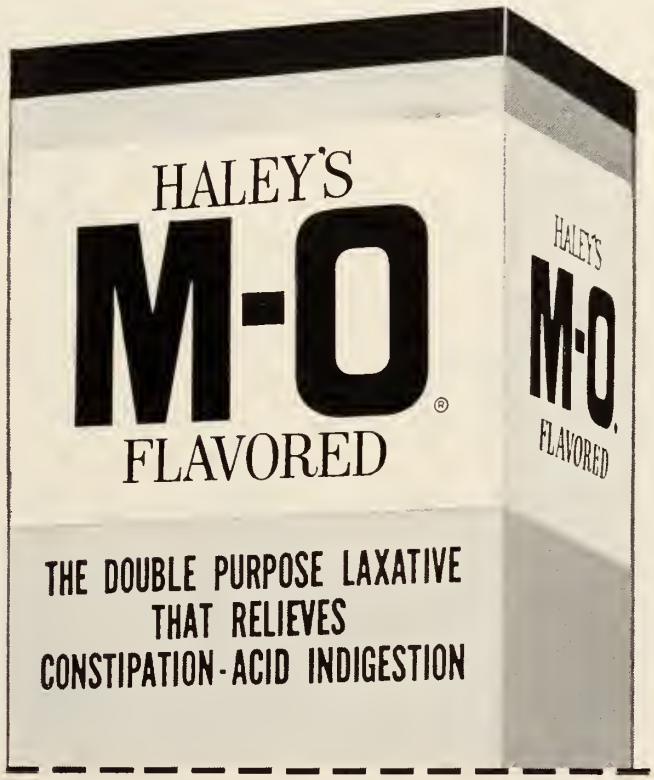
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MSMS Seminar Urges Community Service

(See photos on Page 248)

The more than 150 doctors who participated in the recent "MSMS Annual Seminar—On Community Relations" in Lansing on January 24 heard many suggestions for expanded service activities in their own home town.

Each of the speakers suggested that community affairs activities really do the best job of helping the community better understand the views and concerns of doctors of medicine. The speakers pointed out, too, that an understanding on the local level is necessary to effect cooperation on state and national levels.



Chairman Harold Kessler, M.D.

During the short business meeting, Harold Kessler, M.D., Alpena, longtime secretary of the Alpena-Alcona-Presque Isle County Medical Society, was elected chairman of the County Secretaries for 1964, and will serve as co-chairman for the 1964 Seminar.

Awards Luncheon

A highlight of the program was the Annual Awards Luncheon when six MSMS members received awards as presidents of national medical organizations, and six outstanding Michigan men received special MSMS citations.

MSMS President C. I. Owen, M.D., presented the National President's Awards to M. Duane Sommerness, M.D., Traverse City, president of the Association of Medical Superintendents of Mental Hospitals; Albert D. Reudemann, M.D., Detroit, president of the American Academy of Ophthalmology and Otolaryngology; Max Karl Newman, M.D., Detroit, president of the American Academy of Physical Medicine and Rehabilitation; Jerome W. Conn, M.D., Ann Arbor, president of the National Diabetes Association; Harold F. Falls, M.D., Ann Arbor, president of the Association for Research in Ophthalmology; and Frederick C. Swartz, M.D., Lansing, president of the Joint Council to Improve Health Care of the Aged.

Recipients of the other awards were William McNary, Detroit, "Distinguished Health Service Award" for service as president of Michigan Blue Cross; Ralph Reed, Detroit, "Outstanding Health Service Award" for excellent coverage of health and medical news in the *Detroit News*; E. I. Carr, M.D., Lansing, "Distinguished Health Service Award" for long service as president of the Michigan Foundation for Medical and Health Education; Leon A. Sweet, Ph.D., Detroit, "Distinguished Health Service Award" for outstanding research with Parke, Davis & Company; Luther R. Leader, M.D., Birmingham, "Distinguished Health Service Award" for effective liaison for medicine with industry and government, and Lawrence A.



Photomotograph

A five-minute test with the Burdick Photomotograph indicates the patient whose record is shown above is hypothyroid. The entire procedure for this reliable diagnostic test for thyroid dysfunction — *positioning the patient, connecting the photomotograph to the electrocardiograph, tapping the Achilles tendon, checking the results* — takes but a few minutes, and the record is available for immediate diagnosis and permanent filing.

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Drolett, M.D., Lansing, "Distinguished Health Service Award" for long service as the chairman of the MSMS Legal Affairs Committee.

Two Panels

The morning portion of the Seminar developed the theme of "Responsibilities of Physicians in Community Affairs." R. W. Teed, M.D., Ann Arbor, chairman of the MSMS Public Relations Committee and co-chairman of the Seminar, presided. O. J. Johnson, M.D., Bay City, President-Elect of MSMS, introduced the morning speakers. Responsibilities of physicians in urban affairs were suggested by Arlon Ley, Grand Rapids; in rural-suburban affairs by D. Hale Brake, Stanton; in school affairs by C. R. Anderson, Ypsilanti, and in service and business organizations by Robert H. Albert, Saginaw.

The Awards Luncheon featured a report on "The Washington Scene" by E. B. Howard, M.D., Chicago, Assistant Executive Vice President of the American Medical Association. (An editorial on page 298 contains many of the significant quotations made by Doctor Howard.)

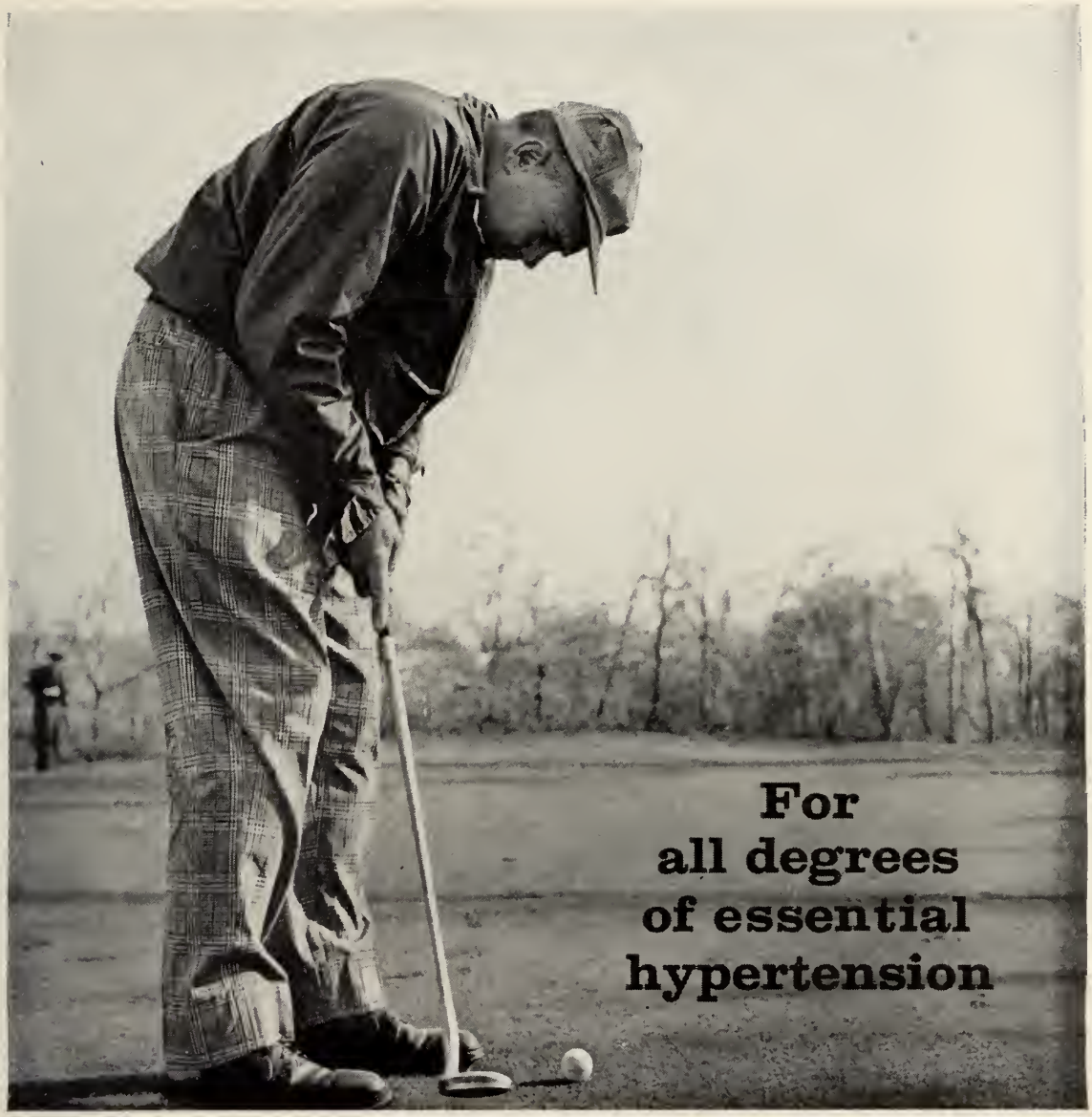
The afternoon panel concentrated on "Physicians Act to Meet Challenges in Community Affairs." Robert J. Mason, M.D., Birmingham, chairman of the MSMS County Societies Committee, moderated. The following gave practical suggestions—John R. Rodger, M.D., Bellaire, chairman of the MSMS Committee on the Study of Prevention of Highway Accidents, on safety projects; Everette Gustafson, M.D., Pontiac, on career recruitment; Carl J. Sprunk, M.D., Melvindale, on medical self-help courses; Otto K. Engelke, M.D., chairman of the MSMS Legal Affairs Committee, on explaining the MAA program; R. E. Anderson, M.D., Flint, on youth fitness activities, and Louis F. Hayes, M.D., Gaylord, on explaining the cost of prepayment protection.

Howard T. Knobloch, M.D., Bay City, as acting chairman of the County Secretaries, presided in the afternoon and D. Bruce Wiley, M.D., Utica, MSMS Secretary, made some timely announcements.

The Seminar was concluded with pertinent remarks by O. B. McGillicuddy, M.D., Lansing, chairman of The MSMS Council.

One secret of a speakers bureau's success is the careful selection of timely, interesting topics for presentation to local groups. Catchy titles also help "sell" local groups on medical programs. Here are medical society suggestions for titles for some of the suggested subjects: "Too Fat?", "Quacks and Charlatans—How Gullible Can We Get?" "Why Executives Drop Dead," "How to Live with High Blood Pressure," "Calm Those Nerves," "Cancer—Exit Pessimism," "New Drugs: Blessings and Dangers," and "From Witchcraft to Isotopes."

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Rautrax-N combines Raudixin (antihypertensive-tranquilizer) with Naturetin c̄ K (antihypertensive-diuretic) for greater antihypertensive effect and greater effectiveness in relief of hypertensive symptoms than produced by either component alone. Rautrax-N is also flexible (may be prescribed in place of Raudixin or Naturetin c̄ K) and economical (only 1 or 2 tablets for maintenance in most patients).

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†Hutchison J. C.: Current Therap. Res. 2:487 (Oct.) 1960.

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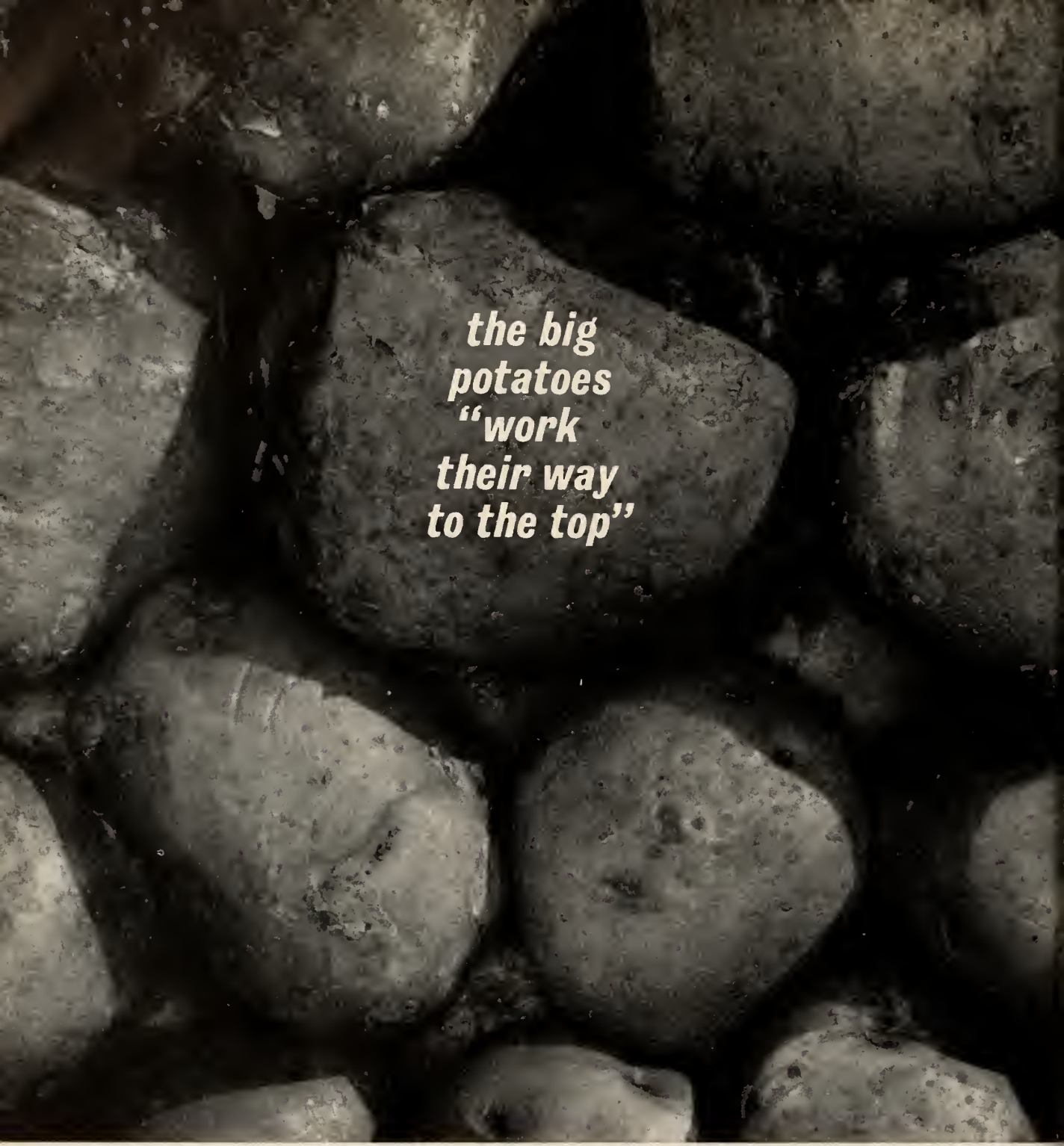
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Examination of the Injured Hand

William C. Grabb, M.D.
Reed O. Dingman, M.D., F.A.C.S.
Ann Arbor, Michigan

THE HANDS, because of their exposed position and continual use in industry, household tasks, hobbies and sports, are frequently injured. The basic fundamentals and common pitfalls in the examination of the injured hand will be discussed.

When the patient is first seen in the office or emergency room, a detailed history of the mechanism of the injury is imperative. It is important to know how much time has elapsed since the injury, the position of the hand at the time of injury, the inflicting agent, the amount of contamination and the type of first aid treatment.

The dressing should be removed under sterile precautions. The examiner should wear a mask and observe sterile precautions. Wounds of the skin and any loss of skin should be noted. Observation of the injured hand as it rests on the arm board will provide important information. Normally, in the position of rest (Fig. 1), the fingers of the hand will lie in moderate flexion which increases in degree from the index to the little finger. The thumb lies next to the index finger with its volar surface perpendicular to that of the other fingers. The examiner can cause the fingers to extend by passively flexing the hand at the wrist. This technique can be helpful in the examination of children, malingerers, patients who hesistate to move their fingers because of fear of pain, and in the anesthetized patient.

Further information in regard to severed tendons or nerves can be gained by having the patient perform certain movements with his fingers. It is best to demonstrate what you want him to do with your own hand and then have the patient practice it with his normal hand before attempting to repeat it with the injured extremity. Only complete absence of motion at a joint is of diagnostic significance. Any weak motions may be due either to the anatomical juncture of a severed and an intact tendon distal to the point of injury, or to the protective splinting of an intact tendon adjacent to a painful wound. Often in cases where there is weak movement at a finger





W. C. Grabb



R. O. Dingman

From the Department of Plastic Surgery, St. Joseph Mercy Hospital, and Department of Surgery, School of Medicine, University of Michigan, Ann Arbor, Michigan.

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joint only operative exploration can prove whether or not a particular tendon has been severed.

A laceration at the level of the middle phalanx on the flexor surface of the hand (Fig. 2) may sever the flexor digitorum profundus tendon and one or both of the volar digital nerves. With the hand at rest, the distal interphalangeal joint lies in extension and the patient is unable to flex the tip of the finger. Sensory nerve loss due to division of one or both volar digital nerves can best be ascertained by a pin prick on the medial and lateral sides of the finger tip. In children, this test should be reserved until the end of the examination. The proximal portion of this lacerated flexor digitorum profundus tendon will retract only to the base of the proximal phalanx of the finger where it is held by the vinculum tendinum longa and lumbrical muscle from further retraction. The flexor pollicus longus tendon in the thumb is an exception, as it has no lumbrical muscle and will often retract into the wrist. Primary repair of tendons lacerated at the level of the middle phalanx is usually indicated.



Fig. 1. Much can be learned by observing the position of the fingers of the hand. The examiner can cause the fingers to flex and extend by passively extending and flexing the wrist.

A laceration between the distal palmer crease and proximal interphalangeal joint crease (Fig. 3) may result in severance of the flexor digitorum sublimis and profundus tendons as well as one or both of the volar digital nerves. This is no man's land where the unyielding osteofibrous tunnel for the flexor tendons, formed by the fibrous flexion sheath and the proximal phalanx, will usually become adherent to any primarily sutured tendons and prevent them from gliding in a normal manner. Examination of the hand at rest reveals that both the proximal and distal interphalangeal joints lie in extension and the patient is unable to actively flex either of these joints. Sensory nerve loss, due to severance of either of the volar digital nerves, should also be tested by the reaction to pin prick on the medial and lateral sides of the fingers. Again, the flexor digitorum profundus tendon will retract only 3 or 4 centimeters into the mid-palm, being held by the lumbrical muscle. The flexor digitorum sublimis will retract into the proximal palm. The best treatment here is simply to suture the wound of the skin without the meddlesome trauma of searching for the tendon ends. After complete healing, definitive treatment consists of a secondary tendon graft procedure.

A laceration on the flexor surface of the wrist (Fig. 4) may involve any or all of the extrinsic flexor tendons to the fingers and wrist, the median and ulnar nerves, and the radial and ulnar arteries. When all of these structures are divided, all of the fingers lie in extension with no movement on active flexion. When only some of these structures are divided, the examiner must be ready to recall the anatomy of this region. It should be remembered that with the other joints locked, the flexor digitorum profundus flexes the tip of the finger, the flexor digitorum sublimis flexes the proximal interphalangeal joint and the interosseous and lumbrical muscles through innervation mainly by the ulnar nerve act to flex the metacarpophalangeal joint. Loss of ulnar nerve function can be determined by inability to abduct and adduct the fingers while they are

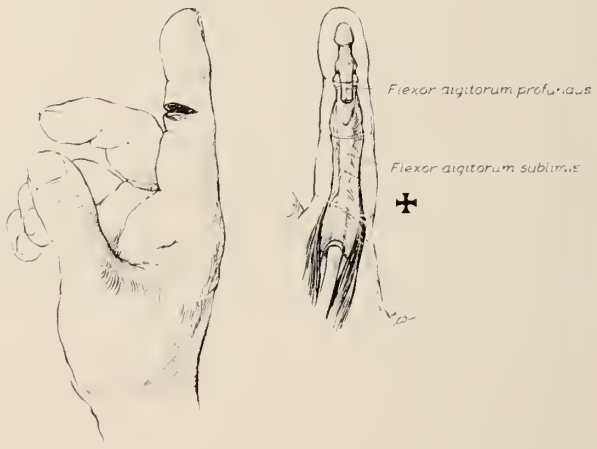


Fig. 2. Laceration at level of the middle phalanx. The flexor digitorum profundus is severed at this level and retracts only about an inch, being held at "X" by the vinculum longa. One or both of the volar digital nerves are usually severed in this injury. A pin prick on the medial and lateral sides of the finger tip will determine whether there is a sensory nerve loss.

held in extension, inability to scrape the thumb across the palm of the hand toward the base of the little finger or loss of sensation to the volar surface of the little and ulnar half of the ring finger. Loss of median nerve function can be determined by inability to abduct the thumb directly upward away from the palm or loss of sensation to the volar surface of the thumb, index, middle and radial half of the ring finger.

There are several pitfalls in the examination of the hand lacerated at the wrist. One common error occurs when only one or two of the flexor digitorum profundus tendons are divided. In this instance, the patient may have partial flexion of the tip of the finger due to intercommunication of profundus tendons distal to the point of injury, particularly in the case of the

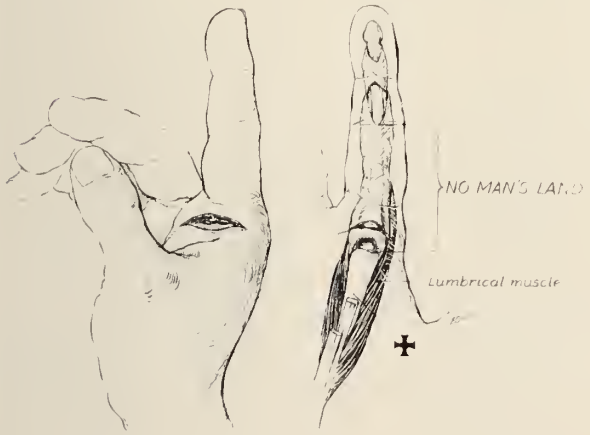


Fig. 3. Laceration between distal palmar crease and proximal interphalangeal joint crease. This is no man's land. Attempts at primary suture of tendons in the unyielding fibrous flexion sheath at this level may result in adhesions and disaster. The flexor digitorum profundus retracts a short distance into the palm, being held at "X" by the lumbrical muscle. The intrinsic muscles still flex the metacarpophalangeal joint.

profundus to the middle, ring and little fingers. Another pitfall is the failure to recognize division of the more superficial sublimis tendons, as their function of flexion at the proximal interphalangeal joint can also be accomplished by the flexor digitorum profundus. Test for the sublimis alone can be performed by the examiner holding the tip of the adjacent finger in extension while the patient attempts to flex the injured finger. In this way, the profundus is immobilized because of its intercommunications at the wrist and only the sublimis is allowed to act. Another source of error is in testing the motor function of the ulnar nerve by adduction and abduction of the fingers. The patient should hold his fingers and hand on a flat surface for this test so that the weak adduction and abduction by the flexor an dextensor tendons cannot be brought into play. Treatment of the divided tendons and nerves at the

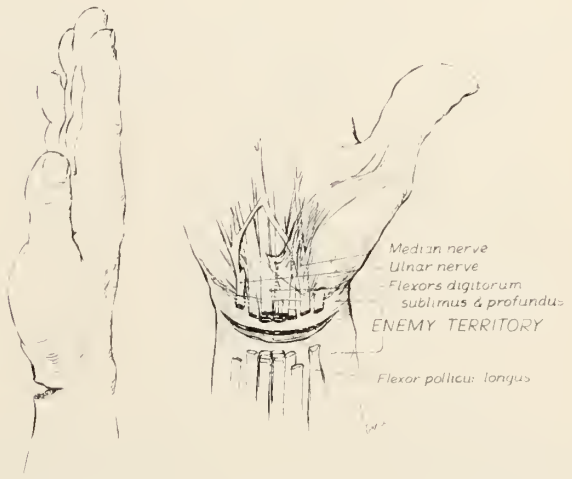


Fig. 4. Laceration at the wrist. This is enemy territory where despite careful repair of tendons, nerves, and arteries a tragic claw hand may result. There is no flexion of the interphalangeal joints due to severance of flexor tendons and no metacarpophalangeal joint flexon due to loss of median and ulnar nerve innervation of the lumbrical and interosseous muscles.

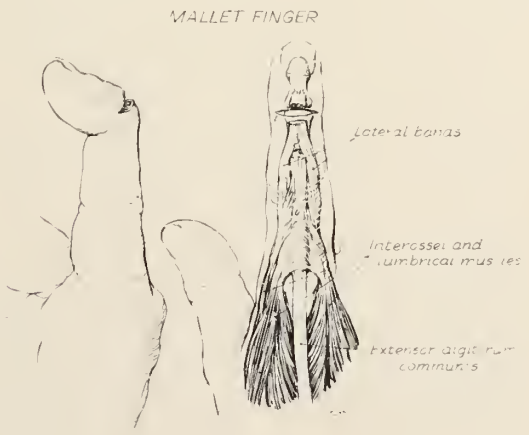


Fig. 5. Laceration at distal interphalangeal joint. This is the typical mallet finger deformity due to division of the lateral bands of the extensor expansion as they insert on the distal phalanx. Lacerations on the dorsum of the hand usually occur over the joints as they are the most prominent part of the finger when the hand reaches to grasp an object.

wrist should be carried out primarily. When all of them are severed, priority should be given to suturing the median and ulnar nerve, the flexor pollicus longus

and the four flexor digitorium profundus tendons. By the use of the microsurgical technique as described by Jacobson, suture of the radial and ulnar arteries is also feasible. It should be mentioned that the wrist

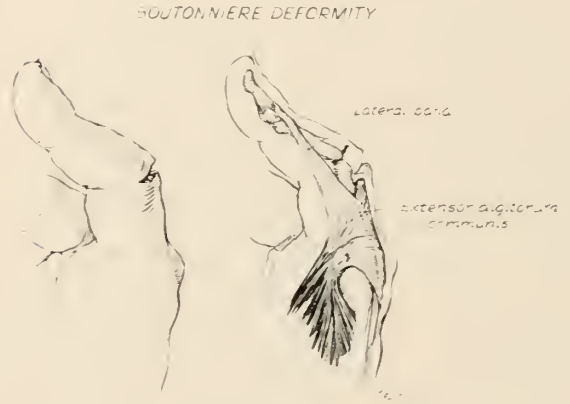


Fig. 6. Laceration at proximal interphalangeal joint. The extensor digitorum communis tendon is lacerated as it inserts into the middle phalanx. The deformity may not be immediately apparent as the lateral bands may continue to extend the joint for a period of days until they gradually slip around to the side below the axis of the joint, where they act to flex the proximal interphalangeal joint and extend the distal interphalangeal joint. This is the boutonniere deformity.

has been termed enemy territory in order to point up the grave funtional disability of the clawed hand that may result from even the very best treatment of lacerations in this region.

A laceration at the distal interphalangeal joint on the dorsum of the finger (Fig. 5) often divides the lateral bands of the extensor expansion as they join to insert on the distal phalanx. At rest the distal interphalangeal joint lies in partial flexion and the patient is unable to actively extend the tip of the finger. This is known as the mallet finger deformity. There is no sensory nerve supply to be concerned about here as the dorsal distal two-thirds of the finger is supplied by the volar digital nerves. One error in the examination of lacerations at the interphalangeal joint of the thumb is related to the fact that in addition to the extensor pollicis longus there as fibers inserting into a dorsal aponeurosis from extensor pollicis brevis, abductor pollicis brevis and adductor pollicis. Any one of these muscles can provide weak extension of the tip of the thumb when the extensor pollicis longus has been severed. Treatment of this injury in any of the fingers should consist of primary tenorrhaphy.

A laceration at the proximal interphalangeal joint on the dorsum of the finger (Fig. 6) often severs the insertion of the extensor digitorum communis as well as the midband of the extensor expansion. Examination may reveal no initial deformity, as the lateral bands are held on the dorsel side of the joint axis by central fibers of the extensor expansion and thus continue to extend this joint. Deformity due to this injury often does not occur for several days until the lateral bands gradually slip around the sides of the joint and act on the volar side of the joint axis, resulting in flexion of the proximal interphalangeal joint, while they continue to produce extension at the distal interphalangeal joint. This has been termed the boutonniere deformity. To avoid the pitfall of failing to recognize severance of the extensor tendon, it is advisable to examine the tendon carefully under sterile conditions, using skin hooks to retract the skin. The treatment here is primary tenorrhaphy, which often is a difficult procedure at this level.

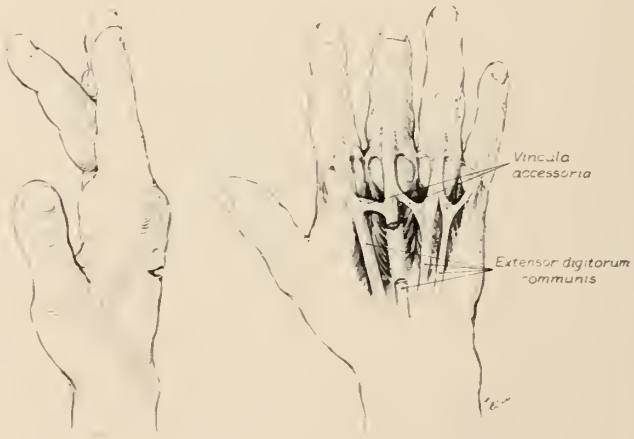


Fig. 7. Laceration on dorsum of the hand. Though the metacarpophalangeal joint cannot be extended due to severance of the extensor digitorum communis tendon, it is still possible to extend the other finger joints by means of the lateral bands motored by the intrinsic muscles. The vincula accessoria between the tendons to middle, ring, and little fingers may act distal to the point of injury to produce some extension of the metacarpophalangeal joint.

A laceration on the dorsum of the hand (Fig. 7) may sever one or more of the extensor digitorum communis tendons. Examination may reveal that the metacarpophalangeal joint lies in partial flexion. A more conclusive test is to have the patient hyperextend the metacarpophalangeal joints with the interphalangeal joints flexed as in the movement which precedes striking a piano key. If one of the extensor tendons is divided, the finger which it serves will immediately straighten out with its metacarpophalangeal joint flex-

ed. One pitfall in this examination is that the vincula accessoria which unite some or all of the extensor digitorum communis tendons may act distal to the point of injury to allow weak extension of the metacarpophalangeal joint. Treatment of lacerated tendons on the dorsum of the hand should consist of primary tenorrhaphy.

The examination of the injured hand is not complete without adequate x-rays to rule out the presence of fractures.

Summary

The basic fundamentals for the examination of the injured hand have been presented. Emphasis has been placed upon the observations which the examiner should make and the movements which he can ask the patient to perform in order to detect the presence of severed tendons or nerves at various levels on the flexor and extensor surfaces of the hand. The common pitfalls which may be troublesome to the examiner are discussed.

Tighten Drug Laws

Influenced strongly by the thalidomide incident, the recent Congress approved legislation giving the Food and Drug Administration more control over the prescription drug industry.

The Kennedy Administration and Sen. Estes Kefauver (D., Tenn.) used the thalidomide incident after prospects of passage of a strong drug bill waned. However, they were unable to get all they wanted.

The new law empowers the FDA to require "substantial evidence" of the efficacy, as well as safety, of new drugs before licensing them for marketing.

The AMA had warned Congress that this might lead to a test of relative efficacy which could result in potentially helpful drugs being barred from sale. The AMA contended that the old FDA requirement that a drug live up to its label claims was a sufficient test of effectiveness. The Pharmaceutical Manufacturers Association warned that drug research might slow down as a result of the new law.

Among major provisions of the new law:

1. Authorizes the FDA to swiftly suspend any drug which it suspects is dangerous.

2. Requires that the generic name of a drug be printed on the label in type half as large as that for the trade name.

3. Extends the time during which FDA may review a new drug application before it must be approved or disapproved.

4. Authorizes the HEW Secretary to establish generic names for new drugs.

5. Authorizes the HEW Secretary to prevent testing of drugs on humans if he determines there has not been sufficient preclinical testing.

6. Requires batch certification of all antibiotics.

7. Physicians will be required to get the consent of the patient or a close relative, for treatment with experimental drugs except in instances where the physician feels that it would not be feasible or would be contrary to his professional judgment. Consent already is a part of the code of ethics of the American Medical Association.

Propionyl Erythromycin Ester Lauryl Sulfate As a Cause of Jaundice

Case Report

Lawrence H. Wilk, M.D.
Carl E. Badgley, M.D.
Ann Arbor, Michigan

DURING the past fifteen years, the medical profession has observed the introduction of many new drugs, more so than at any time in medical history. Most of these medications have been extremely useful. Careful testing has kept complications and side effects to a minimum. However, in spite of careful evaluation, occasional side effects do not become apparent until the medicinal is used for some time. Such is the case with Propionyl Erythromycin Ester Lauryl Sulfate.

Erythromycin was introduced in 1952 and other than mild gastric irritation it was claimed as one of the safest antibiotics.[1] In 1958, the Propionyl Erythromycin Ester of Lauryl Sulfate was introduced because it produced higher and more prolonged blood levels as compared with the Erythromycin base.[2] In fact, the drug proved to be quite successful, as indicated by the more than 20 million prescriptions written since its introduction,[3] and its side effects have been minimal. But with time and use of this apparently improved antibiotic, a complication has become evident.

At this point, credit should be given to Eli Lilly and Company, the producer of Ilosone, the first to publish the information concerning possible occurrence of jaundice during the administration of this drug, in a letter which was sent to physicians in August, 1961. This was followed by two letters[4,5] and an editorial[6] in the October 7, 1961 issue of the *Journal of the American Medical Association* on the same subject. Having a case of our own and realizing that although the drug is widely used, this complication is not well recognized, we are prompted to present our patient and review the information available to date.



Author
CARL E. BADGLEY, M.D.

Case Presentation

M.F., a 52-year-old white woman, has had rheumatoid arthritis for about thirty years. She has been on steroids for the past ten years and at the time of this admission was tapered to 4 mgm of prednisolone per day. Because of excessive pain and disability of the right hip, a cup arthroplasty was performed on December 19, 1961, followed by an uneventual post-operative course until January 1, 1962, when a pin-tract infection from the skeletal traction apparatus was noted. The wire and traction were removed, the wound was treated directly with warm soaks, and Ilosone was started in doses of 250 mgm orally every six hours. Culture revealed a coagulase positive staphylococcus sensitive to erythromycin. The patient got along well and the pin-tract infection was clearing.

On January 13 (the thirteenth day of Ilosone therapy), the patient complained of headaches. The next day, she developed anorexia, nausea, mild upper abdominal cramps, and malaise. On the fifteenth day she spiked a fever to 101° F. At first, the flu syndrome was considered. But on the seventeenth day, although the cramps and fever were gone, she had an enlarged liver about two inches below the subcostal margin which was tender and smooth edged. She had only questionable jaundice, no dark urine nor light stools. All medication except Ilosone was discontinued and the following laboratory studies were obtained: Serum proteins 6.7 mgm per 100 ml with albumin 4.3 mgm per 100 ml and globulin 2.4 mgm per 100 ml with an A/G ratio of 1:8, serum bilirubin 2.8 mgm per 100 ml with 1.4 mgm per 100 ml direct fraction, alkaline phosphates of 42 King-Armstrong units, transaminase (SGOT) 250 units, cephaline flocculation was negative, serum amylase 50 units, prothrombin time of 70 percent, and a normal hemogram and white blood count. Attempts at cholecystogram failed, first, because the patient regurgitated the dye and, secondly, because the dye lingered in the stomach. Finally, on the twenty-third day, an intravenous cholecystogram was done and revealed the bile ducts but not the gall bladder. However, prior to this, the patient's jaundice increased and she even developed pruritus and a rash. On the nineteenth day, the Ilosone was discontinued and the jaundice began to clear and was gone within two or three days. She resumed her postoperative physical therapy program and was discharged ambulatory with a walker, without jaundice or hepatomegaly on March 1, 1962. An oral cholecystogram done the day of discharge was read as normal.

From the Department of Surgery, Section of Orthopaedics, University of Michigan Medical Center, Ann Arbor, Michigan.

Discussion

As evidenced by the above case, the type of jaundice involved is an intrahepatic cholestasis similar to that seen with other medications, such as Chlorpromazine, Prochlorperazine, and Methyl Testosterone groups. This jaundice may mimic both extra hepatic obstruction and infectious hepatitis.[7,8] The symptoms are usually anorexia, nausea, fatigue, accompanied by fever, chills, and at times abdominal or chest pains, followed by jaundice with possibly pruritus and a rash.[1,4,7,8] The laboratory studies should indicate an elevated direct reacting bilirubin, negative or weakly positive cephalin flocculation and thymol turbidity tests, elevated SGOT (transaminase) levels in the range of 100 to 300 units, peripheral eosinophilia, normal cholecystograms, and in some cases an elevated alkaline phosphatase level.[2,3,4,7] This side-effect is thought to be a hypersensitivity reaction[1,3,6] because of the increased eosinophile count, rapid clearance of the jaundice with discontinuation of the drug, and rapid recurrence of the jaundice when challenged again. The hypersensitivity may be due to the Lauryl Sulfate factor.[6] Actually, Lauryl Sulfate is a sodium salt used as a wetting agent in toothpastes, shampoos, and some household detergents.[6] Thus, the original exposure can occur prior to the use of Propionyl Erythromycin Ester Lauryl Sulfate. However, in a recent report,[8] one of the patients received only Propionyl Erythromycin Ester, since the episode occurred before the Lauryl Sulfate derivative was available. This might indicate that the Propionyl Erythromycin component is the causative factor.[3]

This problem, as of the present time, is unresolved. Robinson[7] reported hepatotoxicity in 10 of 80 patients receiving Propionyl Erythromycin Ester Lauryl Sulfate in amounts of 250 mgms four times each day for fourteen days or longer. Complete blood counts and liver studies were normal before administration, but in ten the serum glutamic pyruvic transaminase became elevated between the fourteenth and twenty-first days. Only two patients became clinically jaundiced. When the drug was stopped, the transaminase level returned to normal. Three of these patients were given challenging doses of 500 mgms and the findings promptly returned and then regressed when no further medication was administered. A liver biopsy showed periportal infiltration with lymphocytes, a few PMN's, and many eosinophils, no bile stasis but the patient was not jaundiced. In another study,[8] two patients received challenging doses with similar results. And in a third group, one patient received the drug three times and each time had prompt recurrence of the jaundice.[1] Havens[8] noted a strong history of allergy in his four cases. This sensitivity has not been reproducible in animals.[3] Except for one case of a patient who consumed repeated large amounts of the medication, the exact amount being unknown, and who six months after recovery from the jaundice still exhibited hepatomegaly, no deaths or permanent liver damage has been reported. Thirty-five other cases are known to Eli Lilly and Company.[3]

Summary

The purpose of this report is not to advocate the use or the discontinuation of Propionyl Erythromycin Ester Lauryl Sulfate from the armamentarium of antibiotics. We only desire to present this complication to arouse the awareness of other physicians using this antibiotic. The initial symptoms including jaundice appear between the tenth and twenty-first days of continuous therapy or after several courses.[3] The findings disappear readily with the discontinuance of the medication without apparent residual effects.[3] Because the symptoms as described here and with the use of other medications[7] may mimic viral hepatitis, one wonders whether the recent sharp increase in the incidence of viral hepatitis over the past two years may not in part be due to drug induced syndromes.

Acknowledgments

We wish to acknowledge with appreciation the assistance of George Thompson, M.D., of the Internal Medicine Department, who made us aware of this problem as a cause of jaundice in our patient; of Keith Henley, M.D., of the Internal Medicine Department, who advised us on managing the patient's jaundice, and of H. V. Kuder, M.D. and Mr. Walter Stein of the Eli Lilly and Company, for supplying a great deal of the information.

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Osteoporoses: Their Nature And Pathogeneses

Harold M. Frost, M.D.
Detroit, Michigan

IT IS the purpose of this article to review briefly some modern knowledge of the nature of the osteoporoses essential for understanding them and to outline the nature of the dynamic cellular disturbance immediately causing them. The material is aimed at the clinician. Because of a quiet and recent revolution in our understanding of the osteoporoses much of the present text will be new to clinicians. A discussion of causes in the conventional sense is omitted, justification being that whatever they may be, they must turn the handles of the "faucets" described here to affect the skeleton.

Basic Concepts and Dynamics of Osteoporoses

1. *Osteoporotic Bones: Osteoporotic Skeleton.*—One which contains less bone than a normal of similar age, sex, and weight has.[13,14] While amount of bone is best expressed in terms of volume, the reasons are not pertinent here. A normal adult has about 1.5 liters of bone. It is important to understand there is no characteristic bone *quality* of osteoporotic skeletons in general.[5] Earlier teaching erroneously told us there was normal quality in osteoporotic skeltons in general.

2. *Osteoporotic Skeletons: A Sign.*—Like the blood sugar, hemoglobin, and BUN, an osteoporotic bone or skeleton is a physical sign, not a disease. Like most physical signs, many different diseases may produce the sign. A disease producing an osteoporotic skeleton is called an osteoporosis, and an osteoporosis has, in addition to an osteoporotic skeleton, numerous other physical, chemical, and x-ray signs plus symptoms, incidence and so on.[3]

3. *Specific Osteoporoses.*—When speaking of an osteoporosis as a disease, the disease should be specified, i.e.: thyrotoxic osteoporosis, senile osteoporosis, Cushing's osteoporosis, congenital osteoporosis. Specify the disease and, incidentally, the abnormal skeletal physiology present in each case.[5,7]

4. *Skeletal Balance.*—The amount of bone in any skeleton is the result of the balance between bone formation and bone resorption, averaged over all time before the moment of observation. This balance is called skeletal balance and given the symbol B_{sk}. A normal skeletal balance is zero, indicating there is no change in the amount of bone in the skeleton during a year. A B_{sk} of minus 0.02 means that two per cent of the skeleton is lost during a year. A plus balance means a net gain in a year[5] (Fig. 1).

5. *Skeletal Remodelling Rate.*—Bone remodels ceaselessly throughout the span of life. Remodelling is the combined resorption of old bone and formation of new bone which goes on in about 300,000 separate sites in a normal skeleton at any instant.[8,16] The total remodelling in a year is given the symbol V_{tl} and is the total amount of new bone formed and of old bone resorbed. This symbol is also called the remodelling rate. A V_{tl} of 0.05 (about normal for age 40) means that in a year 2.5 per cent of the skeleton was formed and 2.5 per cent was resorbed, the total being 5.0 per cent or, as a decimal equivalent, 0.05[5,6] (Figs. 1 and 2).

6. *Bone Formation Rate.*—The amount of new bone formed in a man in a year is termed the bone formation rate and given the symbol R_f, (which is the same as Whedon's BFR[9]). Normal values for the R_f are 1.0 at age 2, 0.02 at age 35, and 0.05 at age 65.[6]

7. *Bone Resorption Rate.*—The amount of old bone resorbed in a man in a year is the bone resorption rate and given the symbol R_r. Normal values of R_r are numerically similar to those for R_f.[6]

Work on which this text is based was done under Grants 293, Henry Ford Hospital, and A-4186, NIH.

Doctor Frost is Associate Orthopaedic Surgeon, Henry Ford Hospital, Detroit, Michigan.

8. *Congenital and Acquired Osteoporoses.*—There are two fundamentally different types of osteoporoses from the standpoint of the skeletal balance present during the evolution of the disease.

A congenital osteoporosis is one which was always present because the patient grew up being osteoporotic. In these cases a negative skeletal balance never existed. An example is osteogenesis imperfecta.

An acquired osteoporosis is one which developed some time after the patient had a normal amount of bone in the skeleton. A negative skeletal balance is the essential dynamic cause and the only dynamic feature present in all acquired osteoporoses.

This text deals with acquired osteoporoses.

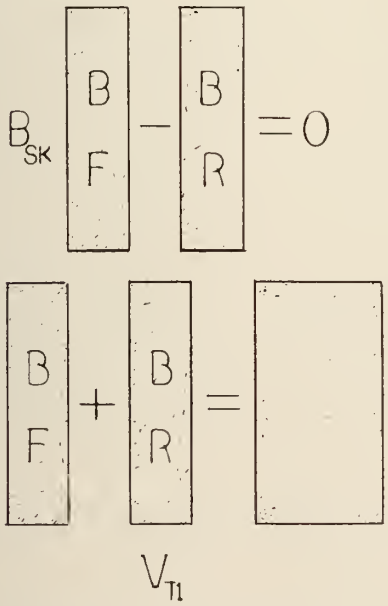


Fig. 1. The top sequence diagrams the meaning of skeletal balance. The bar labelled BF is new bone formed in a year. When an equal amount of bone is resorbed in a year—the bar labelled BR—the difference between the two is zero, meaning there has been no net change in the amount of skeleton in which the formation and resorption process were going on.

The bottom sequence diagrams the meaning of remodelling rate. The amount of bone formed in a year—the bar BF—plus that resorbed in a year—the bar BR—is the total remodelling or the remodelling rate. As above, the skeleton in which the formation and resorption processes are going on is not included in the diagram.

9. *Skeletal Balance and Rate Changes.*—A normal skeletal balance is the direct and necessary result of formation and resorption rates that are equal. It matters not whether both rates be zero, or tremendously accelerated; as long as they are equal, skeletal balance will be zero (which is normal) and there will be no change in the amount of bone in the skeleton with increasing time.

A negative skeletal balance can occur only if more bone is resorbed than formed in a given time. It matters not whether both rates be tremendously accelerated or nearly zero; as long as more bone is resorbed than formed in unit time the skeletal balance will be negative.

$$B_{SK} = R_F - R_R$$

$$V_{TI} = R_F + R_R$$

Fig. 2. The skeletal balance and the remodelling rate are defined arithmetically. Skeletal balance is the new bone formed minus the bone resorbed per year. Remodelling rate is the new bone formed plus the bone resorbed per year. B_{SK} is skeletal balance. V_{TI} is the remodelling rate. R_F is the bone formation rate. R_R is the bone resorption rate.

Skeletal balance is the difference between the formation and resorption rates and only the difference[5] (Figs. 1 and 2).

10. *Resorption and Formation Rates Change in Same Direction but Unequally.*—In theory, formation and resorption rates may be juggled in many ways to produce a negative skeletal balance.

In practice, the situation found so far is this: when formation rate is increased, so is resorption rate. When formation rate is decreased, so is resorption rate. No instance has yet been encountered of increase in one and decrease in the other rate. Obviously the negative skeletal balance must occur in these situations by unequal magnitude of change in formation and resorption rates. When formation rate is increased, resorption is also increased but more. When formation is decreased, resorption is also decreased but less. The reasons for this curious state of affairs are a fascinating but separate chapter in skeletal biology.[5,6]

11. *Remodelling Rate and Rate Changes.*—When both formation and resorption rates are increased, bone is being "turned over" faster than normal. The opposite is true when both rates are decreased. These situations are respectively termed *high remodelling rate* and *low remodelling rate* situations.

12. *Remodelling Rate Determines Bone Quality.*—The quality of the bone in an osteoporosis is the direct result primarily of the remodelling rate. There is a quality characteristic of high remodelling rate, another characteristic of normal remodelling rate, and a third characteristic of low remodelling rate. Sometimes the qualitative changes of unrelated disease—such as osteomalacia—may be superimposed on the above.

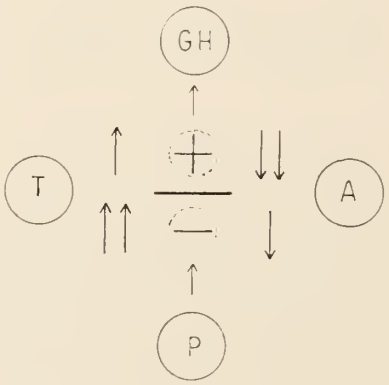


Fig. 3. A diagram of the endocrine factors directly regulating bone remodeling. GH is growth hormone; T the thyroid hormones; A the adrenalcortical hormones; P is parathormone. Plus is new bone formation; minus is resorption. An arrow up means increase in rate caused by the hormone(s) adjacent; arrow down means decrease. Two arrows indicate larger change than one. Note that growth hormone is the only one (in this model) causing positive skeletal balance, and that the thyroid and adrenal hormones govern remodelling rate and are opposite in their effects, the former increasing and the latter decreasing the rate. (Reprinted by permission[5])

At present, there are over 20 characteristics whose sum is the bone quality. Bone ash no longer suffices to describe bone quality.

High remodelling rate quality bone exhibits the following features: increased numbers and diameter of osteoid seams, increased seam specific surface, increased Howship's specific surface, increased percentage of live osteocytes, decreased mean skeletal age, decreased mean skeletal diffusion impedance, decreased Young's modulus, decreased mean skeletal mineral density, decreased microhardness, slightly increased halo volume size, slightly increased ratio of bone protein nitrogen to ash.[5]

Opposite changes in quality are found in low remodelling rate quality bone. Normal remodelling rate quality bone is intermediate between the two extremes. The qualitative features are listed to illustrate their numbers and nature. Fuller discussions of them will be found in the references given.[5,6]

13. *Endocrine Control of Bone Remodelling.*—Although formerly it was thought that estrogens and androgens stimulated lamellar bone formation, it is now apparent that this is not the case.[5,17,18] The manner in which hormones are known to affect bone remodelling is diagrammed in Figure 3.

Briefly, the hormones important in regulating bone remodelling are growth hormone, the thyroid hormones, the adrenal cortical hormones, and parathormone.

These hormones form opposing groups as follows:

Growth hormone favors positive skeletal balance, the remaining three favor negative skeletal balance.

The thyroid hormones increase remodelling rate, the adrenal cortical hormones decrease remodelling rate.

The mode of regulation of these hormones is partly by governing rates of activity of individual cells and partly by governing the total numbers of cells that are present.

Pathogeneses of Osteoporoses

An acquired osteoporosis can develop only if resorption exceeds formation. This is the common *dynamic* disturbance in all osteoporoses. All osteoporotic skeletons have only one common *morphological* feature: a decrease in the amount of bone that would be present in a normal individual of similar age, sex, and body habitus. Osteoporoses are thus a disturbance in quantity of bone and in this respect are comparable as a group to anemias.

In practice, the following three basic types of acquired osteoporoses have been found:

1. *High Remodelling Rate Osteoporoses.*—Examples are the osteoporoses of thyrotoxicosis and acromegaly. In high remodelling rate osteoporoses there are increased formation and resorption rates, the latter being most increased. A characteristic high remodelling rate bone quality accompanies the increased remodelling rate and is directly attributable to various effects of this increase. There is an increased skeletal uptake of tracer material.[2,5,12]

2. *Normal Turnover Rate Osteoporoses*—Examples are postmenopausal and many senile osteoporoses. In normal turnover rate osteoporoses there is little change in remodelling rate from normal, but the skeletal balance is negative. The negativity usually is the result of a slight increase in resorption rate. Relatively normal bone quality is found in normal remodelling rate osteo-

poroses, and unit volume based skeletal tracer uptake is relatively normal.[2,5,15,12]

3. *Low Remodelling Rate Osteoporoses.*—Examples are hyperadrenalcorticoid and some senile osteoporoses. In low remodelling rate osteoporoses there are decreased formation and resorption rates, the latter being least affected. A characteristic low remodelling rate bone quality accompanies these osteoporoses and is directly attributable to the effects of the decreases in formation and resorption[2,12] (Fig. 4).

Discussion

Several points merit rephrasing and reemphasis.

1. An acquired osteoporosis is always the result of a negative skeletal balance, usually over a considerable period of time. Because the skeleton is ceaselessly remodelled and because remodelling is the combined contribution of bone resorption and new bone formation, a *negative skeletal balance means there is an excess of resorption over formation.*

2. While maintaining identical negative skeletal balances, the total amount of bone remodelled in a year may vary widely from nearly zero to a drastically increased value. The remodelling rate therefor has nothing to do with the development of the osteoporotic state.

3. The quality of the bone in an osteoporotic skeleton is the direct result of the remodelling rate characteristic of the cause. There are characteristic qualities of increased remodelling rate and different ones in decreased remodelling rate. An osteoporosis due to a given cause such as thyrotoxicosis almost always has the same characteristic alteration of remodelling rate accompanying it and thus always has a characteristic accompanying bone quality. This quality, while characteristic of the remodelling rate and thus also of particular type of osteoporosis in question, is not characteristic of all osteoporoses. This corrects a long-standing error in the literature on osteoporosis.

4. The skeletal balance and the remodelling rate may and do vary completely independently of each other. Since both are the result of only two activities (bone resorption rate and bone formation rate) this is remarkable and a good example of the consequence of superintegration of basic functions considered by Mayr.[10] Because of this lack of mutual dependence of B_{sk} and V_{rl} it is erroneous to attempt to deduce remodelling rates from balance studies.

Several consequences of clinical importance are implicit in the preceding material.

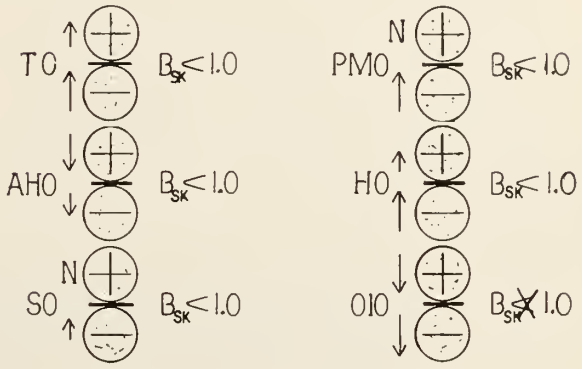


Fig. 4. Some osteoporoses are diagrammed in a dynamic shorthand. As mentioned above, an arrow up means rate is increased; down, decreased. A long arrow means larger change than a short one. Plus means new bone formation, minus means resorption. B_{sk} is skeletal balance. TO is thyrotoxic osteoporosis. AHO is adrenalhypercorticoid osteoporosis. SO is senile osteoporosis. PMO is postmenopausal osteoporosis. HO is hyperparathyroid osteoporosis. OIO is the osteoporosis of osteogenesis imperfecta. B_{sk} is negative in all except the OIO osteoporoses.

5. In order to cure osteoporoses it is necessary to find *pharmacologic* agents which will change a negative skeletal balance to a positive one. This is not the same as trying to increase osteoblastic activity. Probably no single agent will prove effective in all types of osteoporoses because the causes of negative skeletal balance differ in the various osteoporoses.

It is by now well known that for most osteoporoses the gonadal hormones are not the agents needed.

6. In addition to reversing the change in skeletal balance, it will also be necessary to find pharmacologic agents which will return altered remodelling rates to normal values. Almost certainly different agents will be required to lower increased remodelling rates and raise decreased ones.

7. At present, the characterization of remodelling rate and skeletal balance can be done only with techniques that are too clumsy, time-consuming and expensive for routine clinical diagnostic usage.[1,2,9,12,17] There is a great need for development of simple and reliable methods which are acceptable for routine

clinical diagnostic use from the standpoint of safety, reliability, economy, and availability. Probably some tracer method will eventually be found and it may well be related to the tetracycline bone labelling phenomenon[11] reported by Milch, Rall, and Tobie.

8. There is currently active interest, investigation, and discussion about the ultimate causes of some of the osteoporoses. Age, racial, dietary calcium, dietary protein factors and gonadal-adrenal interrelationships are invoked by various authorities to explain various osteoporoses. The outline of skeletal dynamic physiology given here represents the framework within which the ultimate causes of the osteoporoses must operate. Whether the cause is a mineral deficiency, a hormone inbalance, or something else, the immediate cause is an excess of resorption over formation. Skeletal balance is the "faucet" that must be turned by the ultimate cause to produce an osteoporosis, and which must eventually be re-turned by a pharmacologic agent to cure an osteoporosis.

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Describes "Better" Hospitals

Thirteen conditions that tend to make hospitals better organized were found in a study of "The Community General Hospital" by Basil S. Georgopoulos and Floyd C. Mann of The University of Michigan Survey Research Center, recently published by the Macmillan Company, New York. The book (693 pages, $12.50) reports in detail on an investigation of 12 short-stay Michigan hospitals.

Organizational coordination of the hospital's work, the authors find, is more adequate in those hospitals where: (1) Organizational rules and regulations are more clearly defined; (2) Conformity to official policies by organization members is greater; (3) Members share compatible expectations for hospital performance, while medical and nursing staffs better understand each other's work problems and needs; (4) People in related jobs are more willing to assist each other; (5) Tension between interacting groups and "unreasonable" pressures for better performance are less; (6) Work problems are handled promptly and well; (7) The administrator and director of nursing cooperate in problem-solving; (8) Policy decisions which affect work are explained adequately; (9) Patient charts are adequate; (10) The nursing staff has fewer aides; (11) Supervisors are in effective communication with subordinates; (12) Hospital size tends to be smaller; (13) Nursing department coordination is better.

Idiopathic Scoliosis in Fraternal Twins

Thomas F. Scott, M.D.
Robert W. Bailey, M.D.
Ann Arbor, Michigan

SCOLIOSIS in twins has been noted, reported and studied with interest with regard to some clue in pathogenesis. All cases but one of idiopathic scoliosis in twins which have come to our attention and which have been reported, have been thought to have been identical twins. The ensuing case report concerns scoliosis in proven fraternal (binovular) twins.

The first case of scoliosis in twins was reported by Haffner[3] which was secondary to dorsal spine hemivertebrae. A total of five cases of idiopathic scoliosis in twins has been reported in the recent literature. In four cases, the twins were either proven or thought to be identical by similarity in appearance and blood type. Weiser, in 1949, noted identical twins with curves similar in magnitude and situation, but with opposite convexity. Esteve,[2] Codorniu,[1] and Murdoch[6] all reported curves similar in location, magnitude and convexity in identical twins, while Hull[4] noted similar curves in binovular twins.

The curves noted in the above cases, as well as the ones below, had several characteristics in common.

1. They usually fall into the adolescent or preadolescent grouping as outlined by James.[5]
2. The primary curves are dorsal or dorsal lumbar.
3. The heavier twin usually has the larger curve.
4. All cases reported have been in girls.



Fig. 1. Mirror scoliotic curve, preoperative.



Fig. 2. Mirror scoliotic curve one year postoperative.

Case Report

T1 and T2 are fraternal twins, dissimilar in physique, appearance and blood grouping, in which no abnormality was noted until about age twelve. The family is one of modest means and the mother discovered the asymmetry at the time of dress-making. This impression was substantiated at a crippled children's field clinic approximately four months

From the University of Michigan Medical Center, Ann Arbor, Michigan.

later, and when seen in follow-up an additional three months later the curves were felt to be progressing. At this time, the children were referred to University Hospital for further treatment.

body casts with corrective pads and belts were used. The fusion of twin T1 was from D-6 through L-2, and twin T2 s fusion was from D-9 through L-4. Postoperative films demonstrated that correction of nearly 20° was achieved in both.

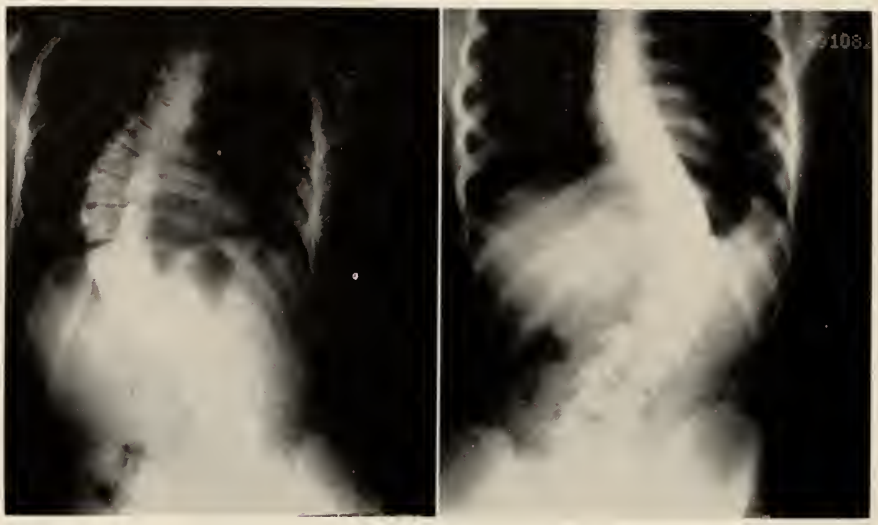


Fig. 3. X-rays of mirror scoliotic curves pre-operative.

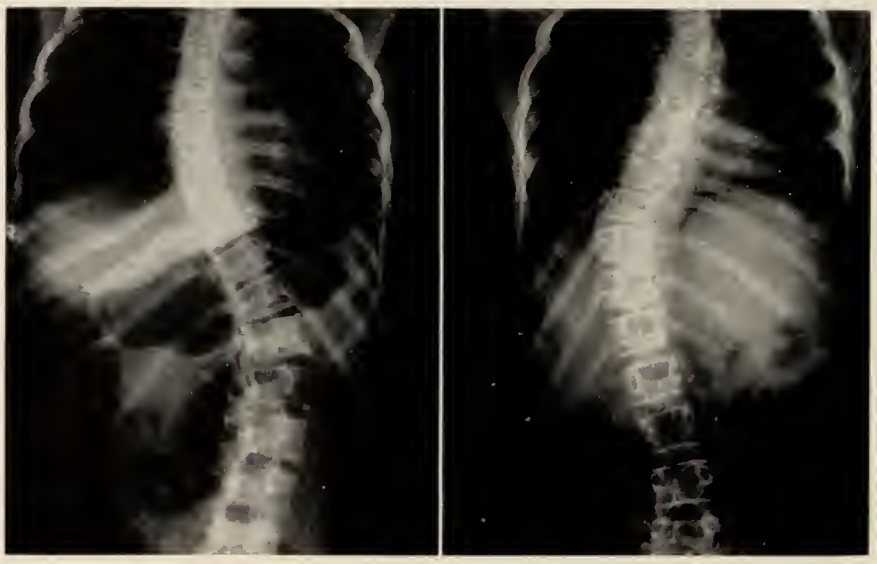


Fig. 4. X-rays of mirror scoliotic curves one year postoperative, correction and fusion.

T1, the smaller of the two, presented with a 45° (Ferguson) lumbar-dorsal scoliosis apex to the right at D10 with a compensatory high dorsal curve. T2, the larger, had a 50° lumbosacral rotoscoliosis apex at the twelfth dorsal vertebra and with compensatory lumbar and dorsal curves. Bending and traction films of both girls demonstrated some correctability of the curves; it was believed that the curves would be progressive.

Accordingly, both of the twins were placed in corrective Cook casts, two-stage spinal fusions utilizing homogeneous bone grafts were carried out, and further immobilization in

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Infantile Cortical Hyperostosis Presenting With Exophthalmos

Case Report

T. W. Bywaters, Jr., M.D.
R. W. Bailey, M.D.
C. J. Carroll, M.D.
G. A. O'Connor, M.D.

Ann Arbor, Michigan

IN THE PAST three decades, more than 100 cases of infantile cortical hyperostosis or Caffey's disease have been reported. George Roske reported from Heidelberg Children's Clinic an illness in a child which now appears to be the first reported instance of this disease.[9] In 1939, Caffey observed periostitis in an infant which was not explained by the known disease entities.[2] Caffey and Silverman in 1945 reported and described four cases and defined the syndrome as separate and distinct from previously known entities[3], and coined the term "infantile cortical hyperostosis". Since that time a mass of information has been accumulated about this disease.

The clinical course typically begins[5] with an infant five months or less of age. The average age of onset is nine weeks. The infant presents with irritability, low grade fever, leukocytosis, elevated sedimentation rate, mild anemia, and pallor. Anorexia and mild diarrhea may occur. Swelling appears early in the course and rather suddenly. It is browny or woody, hard, always in conjunction with the underlying bone. Subcutaneous tissue is not involved. Pseudoparalysis may occur; pleurisy with or without pleural effusion may be present. Local tenderness is present early but local warmth, discoloration, hyperemia, or lymph adenopathy appear later. Bona fide cases apparently do not occur after five months of age at onset.[5]

The etiology of the syndrome has been postulated from infectious, allergic, hereditary, or vascular origins. A thorough search has been made for all types of infectious agents but none have been found by culture or serologic methods.[5] Allergic origin has been postulated and cases presented that appear to be related to dietary intake of cows' milk with reproducible remissions and exacerbations with substitution of Mull-Soy. However, this does not seem to explain the prenatal and natal occurrence of this disease.

Hereditary origins have been postulated, and documented family trees presented.[4,5,7,12] Some of the parental and grandparental cases lack clinical and radiographic documentation.

Some authors[11] have demonstrated pathologically an obliterating intimal proliferation involving small arteries in the area of the diseased bone and regional soft tissues. This is felt to result in regional hypoxia and this in turn presumably reactive osteogenesis. If this vascular phenomenon presents pathologically in all cases, a hereditary tendency conceivably may be applied. It is well known that elements of the fetal circulation normally undergo obliteration during this period; i.e., the ductus arteriosus, umbilical arteries and vein. Application of a similar process to vessels of different size and function is entirely hypothetical and does not explain the lack of occurrence in times before 1930, as radiographs have been searched in retrospect without finding cases in large hospital files.

No irrefutable etiology has been established yet.

Pathologically, the appearance is that of normal but immature lamellar bone formation. Varying degrees of inflammatory changes are present. Initially, the cellularity of the osteogenesis is aggressive, even being compatible histologically with osteosarcoma; whereas later the new bone progressively matures.

Radiographically[5] the appearance is of varying volumes of immature bone deposited about the diaphysis of a long bone between but not involving the epiphyseal plates. The same appearance occurs in flat bones with the new and original cortical margins usually visible. Initially, the cortex of the pathologic bone may be formed poorly. Recovery occurs by medullary enlargement and reduction in thickness of the cortical wall from within. Subsequently, gradual remodelling and decreasing diameter of the diaphysis

From the Department of Surgery, Section of Ohthopaedics, University of Michigan Medical Center, and St. Joseph Mercy Hospital, Ann Arbor.

to normal occurs. Residual is uncommon though synostosis of radius, ulna and adjacent ribs has occurred. Radiographic evidence without clinical disease has been found.[12] Clinical signs are generally absent by the age of one year, and radiographic evidence absent by three years.

Treatment is supportive as the disease is self-limited, though four deaths have been attributed directly to the disease.[5] ACTH and corticosteroids are very effective[1,5,8,12] in ameliorating the disease and halting systemic reaction though many prefer to reserve this for severe cases because of the risk of this therapy.

Sites of involvement[3,4,5,6,8,9,10] include all tubular and flat bones although involvement of the vertebrae, phalanges, carpal and tarsal bones has not been reported. The most frequent sites are mandible, clavicle, and ulna, with frequent occurrence in the frontal and parietal bones, facial bones, ilia or a single scapula. Scapular involvement has been unilateral in any given instance.

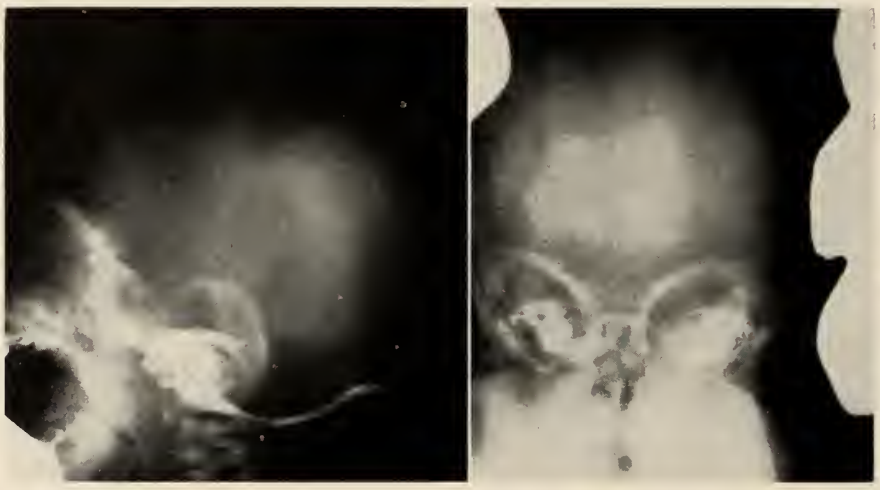


Fig. 1. *(left)* November 9, 1960. Thickening of orbits present on lateral projection of the skull. Soft tissue enlargement of eyelids is apparent.

Fig. 2. *(right)* November 9, 1960. Frontal projection of the skull shows thickening of the bony orbit. Bony encasement of inner ear is projected within the orbit.



Fig. 3. December 15, 1960. Periosteal new bone in large quantities apparent about right tibia and fibula.



Fig. 4. December 15, 1960. Fusiform enlargement of the right leg is demonstrated and is 7.5 inches in circumference at maximum.



Fig. 5. December 15, 1960. Enlargement of both mandibles is seen and exophthalmos, though present, is not well demonstrated in photograph.

The following case illustrates an infant with infantile cortical hyperostosis presenting with unusual and perplexing symptoms later to be clarified by further involvement with the disease.

Case Report

M. W., Negro male, was born August 1, 1960, weighing 9 pounds, 2 ounces. There is no known prenatal, birth or neonatal difficulty. Fourteen older siblings are in the family. He was placed on a condensed milk formula and multivitamins following discharge from the hospital as a newborn. For three weeks no abnormality was noted. On September 1, 1960, he was seen in the Emergency Room of St. Joseph Mercy Hospital in Ann Arbor, Michigan, with a temperature of 101° rectally. An upper respiratory infection was present and out-patient treatment with aspirin and expectorant cough syrup was instituted.

He was next seen on September 15, 1960, at which time a history was obtained of three to four loose stools daily for the past two weeks; he had not gained weight during the interval. Temperature was 101° rectally. He was active with no signs of dehydration. Eyelids were swollen and slight exophthalmos was present. The throat was injected. Remainder of the physical examination was normal and he was admitted to the hospital.

Hemoglobin was 12.5 grams/100 ml., hematocrit 39 per cent; white blood count 17,200 with slight left shift. Urinalysis showed normal flora. Throat culture on September 19 showed alpha and gamma hemolytic streptococcus, Staphylococcus aureus and otherwise normal flora. During admission white blood count ranged from 18,000 to 12,500.

While hospitalized the infant took half strength house formula well but continued to have loose, frequent bowel movements. Shortly after admission he was noted to hold his head in slight extension most of the time. Formula was changed to boiled skimmed milk without change. He was placed on penicillin and streptomycin intramuscularly in accordance with throat culture results and continued a febrile course.

On September 20, 1960, the patient appeared dehydrated and diet was stopped. Intravenous fluids were administered via scalp vein; later hypodermoclysis was administered in both thighs. After three days, diet was progressively resumed without difficulty, but loose stools were still present.

On October 2, 1960, his temperature again rose to 101° and he was noted to be in a position of opisthotonus, resisting attempts at head or hip flexion, though it was possible with moderate effort to flex thighs onto the chest. Lumbar puncture was done and results were found to be normal. Exophthalmos was again noted. Antibiotics and oral intake was continued. Temperature gradually declined until discharge on October 10, when it was 100° rectally. Some extension of the head and exophthalmos was present at discharge. Oral penicillin was continued at home.

He was seen again on November 8 at fourteen weeks of age and admitted to the hospital. The mother gave the history of gradual enlargement of the right leg since discharge from the hospital. The enlargement was hard; never soft or fluctuant. Subjectively, he had been afebrile and had gained weight even though he was not eating well.

Physical examination on admission revealed an infant in no apparent distress. Weight was in the third percentile. Marked bilateral exophthalmos was present and there was a 2 cm. umbilical hernia. The right leg from knee to ankle showed a fusiform, woody, hard enlargement with very slight local heat, apparently non-tender. Spontaneous movement of the affected extremity was diminished. Remainder of the physical examination was normal with no other sign of enlargement. Eye movements were normal despite exophthalmos. Hemoglobin was 11.7 gms/100 ml.; white blood count 13,850 with normal differential and sedimentation rate 19 mm. per hour. Urinalysis was normal and throat culture non-contributory.



Fig. 6. *(above)* May 18, 1961. Bony orbit now relatively much thinner.

Fig. 7. *(below)* May 18, 1961. Remodelling of right tibia and fibula is taking place.

Radiographs of skull and right tibia were obtained. The right tibia and fibula showed a diffuse periostitis. The skull showed apparent thickening of cortical bone of both orbits on lateral and frontal views (Figs. 1 and 2).

While in the hospital the patient did well. Three blood

cultures were sterile. After adjustments in feeding and formula, the patient was discharged with the diagnosis of infantile cortical hyperostosis.

The patient was returned to the hospital as an out-patient on November 17, and was felt to be doing satisfactorily.

On December 15, 1960, he was again seen as an out-patient. The mother had noted for several days a swelling about the right mandible with mild difficulty eating. Examination showed swelling about the mandible. Exophthalmos was less than previously present (Fig. 5). Radiographs of the right tibia showed some maturation of the periosteal new bone (Fig. 3); the mandible showed periosteal new bone, more marked on the left than the right, as well as involvement of the medial third of the left clavicle and second and third left ribs. No further treatment was instituted. Right leg was unchanged (Fig. 4).

Subsequent visits to the out-patient clinic noted no further difficulties and resolution of the previous findings has occurred. On May 18, 1961, radiographs of the skull and right tibia showed partial resolution of the previous findings (Figs. 6 and 7).

From onset of initial symptoms of his disease at seven weeks, the child demonstrated a rather unusual case of infantile cortical hyperostosis. The disease presents in this instance with orbital involvement, with a period of several weeks intervening before other signs of the disease became apparent. The disease appeared in three relatively distinct exacerbations. The vaguity of initial findings resulted in delay in diagnosis of the primary disease. No mention of involvement of the orbit per se has been found in the literature. This appears to be the situation by radiographic and clinical examination in this patient.

Conclusion

1. A brief review of infantile cortical hyperostosis is presented.
2. A case of exophthalmos from orbital involvement with infantile cortical hyperostosis is presented.

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Physiological Abstracts

LIVER THIOL AND ASCORBATE IN MICE TREATED WITH *SALMONELLA* ENDOTOXIN. C. D. Jeffries, Ph.D., Wayne State University.

Endotoxin administered to susceptible animals has been demonstrated to affect a number of liver enzyme systems, among them succinoxidase. This enzyme has been demonstrated to be dependent upon the presence of thiol groups, therefore the effect of endotoxin treatment upon the sulfhydryl level of mouse liver has been investigated.

In preliminary determinations using an iodate titration it was found that the iodate reacting groups of mice administered endotoxin were decreased. Because thiols and ascorbic acid, as well as other substances may be detected in the iodate titration, the silver emperometric titration for thiols has been used. The data substantiated that much of the iodate reacting material was thiol and that the levels of sulfhydryl were lowered in intoxicated animals. The ascorbic acid level determined by the photometric indophenol method was found to be increased in the intoxicated liver.

The changes in the level of thiol appeared within two hours. The effects observed at eighteen hours also reflect, in part, the inanition induced by intoxication.

EPSILON AMINO CAPROIC ACID IN THE TREATMENT OF HEMORRHAGIC COMPLICATIONS OF FIBRINOLYSIN TREATMENT OF EXPERIMENTAL MASSIVE PULMONARY EMBOLI. Carlos Grodsinsky, M.D. and Thomas Gahagan, M.D. Henry Ford Hospital.

Utilizing large doses of fibrinolysin, we were able to dissolve experimental massive pulmonary emboli, but many animals died from hemorrhage, presumably caused by the fibrinolysin. Epsilon amino caproic acid, given in dosage arrived at by biological titration, appeared to counteract the hemorrhagic complications in a subsequent series of animals without interfering with the clot destroying action of the fibrinolysin. Experimental emboli which were uniformly fatal without treatment were used in these experiments.

Abstracts of papers presented at the Detroit Physiological Society, December 13, 1962.

Familial Osteo-Arthro-Onychodysplasia

C. Herbert Wang, M.D.
F. Ross Birkhill, M.D.
Ivor D. Harris, M.D.
Dearborn, Michigan

FAMILIAL osteo-arthro-onychodysplasia is a hereditary dominant, non-sex linked syndrome which is characterized by dysplasia of nails, absence or hypoplasia of patellae, deformities of shoulder, elbow, wrist, knee and ankle joints, often bilateral; and abnormalities of the pelvis including the so-called "iliac horns". Among the more rarely associated manifestations are: spina bifida occulta,[5] pectus carinatum,[6] widening and darkening of the ectodermal element in the iris causing an irregularly wide and dark pupillary border (Lester's sign),[11] angiomastosis of skin,[7] congenital cataract,[7] pes planus,[13] coxa valga,[21] talipes equinovarus and absence of distal interphalangeal joints of the fingers.[3] Various combinations of these manifestations may be found in any affected individual, but the triad, dysplasia of the nails, absence or hypoplasia of patellae, and deformity of the elbows, is the most important.[1]

The individual manifestations of this syndrome have been repeatedly described in the literature during the past one hundred and fifty years. Almost all the cases were reported from Europe and North America.[12,14,21,22,23] Recently one case has been reported from India.[6]

Congenital absence of the patellae has been known since 1820.[12] In 1897, Little first reported a family observed by Sedgewick in four generations of which eighteen persons had no patellae and no thumb nails. Trauner and Rieger in 1925 reported the association of elbow deformities in addition to the nail and patella abnormalities. It was not until 1933 that Turner gave a complete description of the various bone and joint manifestations associated with nail dysplasia. Although he made no mention of the iliac horns, the roentgenogram of one of his patients clearly demonstrates these horns. It was Keiser in 1939 and Fong in 1946 who first called attention to these iliac horns.[5,9] According to Elliott et al,[4] these are actually "iliac spines," because they do not have a round base.

Of a total of about 100 cases collected from the literature, Kohler and Zimmer[10] found forty-seven cases with defects of the thumb nails alone; thirty-seven cases of the thumb and index nails combined and sixteen cases of the toe nail also. The patellae were missing or hypoplastic in ninety-four cases, and in fifty cases there was elbow dysplasia. Jameson et al suggested that iliac horns occur with the aforementioned triad of anomalies in about 30 per cent of the cases.[8] Other manifestations are much less common.

Numerous synonyms have been proposed: hereditary arthrodysplasia associated with hereditary dystrophy of the nails;[21] osteo-onychodysplasia;[13] hereditary arthro-osteo-onychodysplasia associated with iliac horns;[3] familial dyschondroplasia associated with anonychia;[11] Fong's lesion;[6] osseous dysplasia and dystrophy of nails;[15] Turner's syndrome;[22] nail-patella syndrome;[8] hereditary onycho-mesodysplasia.[14]

Clinical Features

Most of the patients are asymptomatic, in spite of rather extensive bone and joint involvement. Their bony abnormalities are usually incidental findings. When there is absence or hypoplasia of patellae, instability of the knee joint or recurrent dislocation may occur. The knees appear flat when extended, square and angular when flexed. They may be easily hyperextended. Patients may complain of frequent falls when running.

When the elbows are affected, especially if there is luxation of the radial head, flexion, extension, supination and pronation may be limited. The carrying angles are increased.

Author
C. HERBERT WANG,
M.D.



From Department of Radiology, Oakwood Hospital, Dearborn, Michigan.

The iliac horns may occasionally be palpable through the gluteus muscles. An abnormal laxity of the wrists and finger joints may be evident.

The nail changes vary from total absence of nail to nails that are scarcely distinguishable from a normal nail, except that they are thinner. Thumb nails are mostly affected as a rule. The changes are less marked across the hand toward the little fingers. Toe nails may also be similarly affected.[10] The typical dysplastic nail may appear normal at its base, although it is actually thinner there than normal. Distally, the nail disappears so that about one half way along the nail bed the fleshy end of the finger turns backward over the nail itself. Patients may therefore have difficulty in picking up small objects. Alternately, the nail may grow to be of normal thickness exhibiting a concave, spoon-shaped contour as opposed to the usual convex surface. Often it possesses a longitudinal central ridge with deep concavities on each side.[21] Hemidysplasia of the outer half (radial side) of the nail may also occur.[3]

When Lester's sign is present, a clear-cut zone of paler pigment occurs around the circumference of the iris and the darker central part is shaped like a clover-leaf. The iris changes are most pronounced in blue eyes.[11]

Albuminuria has also been reported in some cases.[7]



Fig. 1. *(left)* Pelvis showing hypoplasia of iliac wings, presence of "iliac horns" and prominent anterior superior iliac spines.

Fig. 2. *(right)* Lateral roentgenograms of both knees showing hypoplasia of the patellae.

Roentgen Manifestations

Knee.—Patellae may be absent or hypoplastic. The medial condyle of the femur is usually prominent, as is the tibial tubercle. There is genu valgum in some cases. The hypoplastic patellae are usually located on the external aspect of the knees, lying rather high.

Elbow.—There is elongation and deformity with luxation of the proximal end of the radius. The head of the radius is poorly formed and the radio-ulnar articulation is dysplastic. The capitellum is hypoplastic and the trochlear is prominent.

Pelvis and Hips.—There is an increase in the normal concavity of the external surface of the ilium, giving the crest the appearance of an outward flare in its posterior half. There may be hypoplasia of the iliac wings, associated with prominent anterior superior iliac spines. The iliac horns, when present, are symmetrical, bilateral, central posterior iliac processes, which may vary in size. Coxa valga of the proximal ends of the femurs may also be noted.

Shoulder.—The scapula may be underdeveloped. The glenoid fossa is small and shallow. There may be thickening of the axillary border of the scapula with a convex margin. The head of the humerus tends to be smooth and underdeveloped. Its articular surface faces upwards to an unusual degree. The greater tuberosity is less prominent, and therefore the bicipital groove is shallow. The acromial and coracoid processes are small. The acromial end of the clavicle is therefore prominent.

Wrist.—Madelung's deformity and thickening of the ulnar styloid process may be present.

Ankle.—The malleoli, especially the medial malleolus, are prominent. Talipes equinovarus deformity has also been reported. Elliott et al noticed a shortening of calcaneus, absence of the anterior tubercle and

flattening of the adjacent surfaces of talus and calcaneus. The talus shows no waist and the superior margin of its head and body is almost linear.

Other.—Spina bifida occulta of the cervical, dorsal and lumbar spine has been noted.[5,7] Lumbar lordosis, polydactyly, pectus carinatum, pes planus and cavus, and absence of distal interphalangeal joints have also been described.

Case Report

F. B., a 35-year-old white woman, was referred to the Radiology Department for survey diagnostic studies. She complained of right upper quadrant pain of several months' duration. Cholecystogram and upper gastrointestinal study revealed no significant abnormality. However, scout film of the abdomen showed prominent iliac horns with hypoplasia of iliac wings and prominent anterior superior iliac spines (Fig. 1). Clinically, the patient exhibited hemidysplasia of both thumb nails and "square knees." Roentgenograms of the latter revealed hypoplastic patellae (Fig. 2). Studies of the elbows and shoulders were not remarkable. The patient denied any symptoms referrable to the joints. However, she described changes compatible with dysplasia in the thumb nails of her father and all of her four children. Each of them also had "square knees."

Summary

A hereditary dominant, non-sex-linked syndrome, characterized by dysplasia of nails, various deformities of the peripheral joints and sometimes associated with iliac horns has been described.

The literature on its clinical and roentgen manifestations has been briefly reviewed.

A case affecting a 35-year-old white woman and her family has been reported.

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Heat Stroke and Temperature Control

Edgar A. Kahn, M.D.
Ann Arbor, Michigan

IN JULY, 1942, I was in an Army camp in Arkansas during a severe heat wave. For several weeks, the temperature did not fall below 100° F. During one 48-hour period, twelve men from a newly arrived northern training group were suddenly struck down with heat stroke and at least half of these men died. To see young and healthy recruits abruptly develop delirium, with continuous convulsions and death within a few hours, was a shocking experience.

It was soon apparent that all of these patients had stopped sweating previous to the attack. Heat stroke was generally thought to be due to a disturbance in the hypothalamus and the cases we saw seemed to fit very well into this category.

To digress a little, let us consider the craniopharyngioma, a tumor which ordinarily involves the hypothalamus. Before the advent of cortisone, our operative mortality in a series of 51[1] patients with craniopharyngiomas was 41 per cent. Some of these patients died, always in the absence of sweating, with temperatures reaching 108° F. Since the advent of cortisone I have operated upon 22 consecutive patients with craniopharyngiomas with but two postoperative deaths.[2,3] High temperatures were seldom a problem and the improvement in our results suggests that cortisone in same way counteracts the effect of the hypothalamic disturbance created by the operative procedure. Until recently, we believed that the high temperatures associated with heat stroke and those following operations for craniopharyngiomas were caused by a disturbance in the hypothalamus, for in both conditions there was high temperature with absence of sweating.

There is one great difference, however, between patients with the high temperature of heat stroke and those with the high temperature following operations for removal of craniopharyngiomas. This difference is that following the removal of craniopharyngiomas the high temperature is accompanied by circulatory collapse, while the high temperature of heat stroke is at first accompanied by a bounding pulse and normal or increased blood pressure. Before proceeding further, it would be well to compare temperature control in man under normal and under certain pathological conditions.

Under ordinary climatic conditions, about 65 per cent of heat loss occurs from the body surface by the physical processes of convection (15 per cent) and radiation (50 per cent). The cooling effect of the evaporation of sweat from the skin, and, to a much lesser degree, of water from the lungs, accounts for approximately 30 per cent of heat loss. If the environmental temperature reaches the body temperature, no heat will be dissipated from the body surface; and should the environmental temperature be higher than 99 degrees Fahrenheit, heat would actually be absorbed by the body. It is obvious, then, how important sweating becomes in high environmental temperatures. The role played by the humidity of the surrounding air is important since the rate of evaporation of the sweat is dependent upon it.

There is a center in the anterior hypothalamic area[4] which is bilateral and which protects against heat by initiating sweating and by inhibiting the vaso-constrictor center in the posterior hypothalamus, permitting vasodilatation. High body temperature is normally precluded by this peripheral vasodilatation and by the evaporation of the individual's own sweat. If this center in the anterior hypothalamus is disturbed by operations in that region (such as the removal of a craniopharyngioma), there is often a severe temperature disturbance in the nature of increase in temperature with the complete absence of sweating in the presence of normal environmental temperatures. Prior to the advent of hydrocortisone, high temperatures were the bugbear of the neurosurgeon especially when hypopituitarism with its subsequent hypoadrenocorticalism was present. In some unknown way, hydrocortisone exerts a direct antipyretic action and a more important indirect anti-

Doctor Kahn is Professor of Surgery and Chief, Section of Neurosurgery, University of Michigan.

pyretic effect by combatting circulatory collapse in hypoadrenocorticalism.

In cerebral operations upon patients with hypoadrenocorticalism where there is insufficient hydrocortisone to prevent circulatory collapse, extremely high temperatures may be reached and death may take place from the hyperthermia itself. In such cases, however, the body surface, though dry, is comparatively cool to the touch in contradistinction to the hot skin of true heat stroke. This difference in skin temperatures in these two conditions is of fundamental importance, particularly in regard to treatment; for when high temperatures are present in the circulatory collapse of hypoadrenocorticalism, the blood is preponderantly in the splanchnic area and, in the presence of uncontrolled peripheral vasoconstriction, cannot reach the body surface to give off heat. It would be illogical to treat a patient in this condition by cooling an already cool body surface which would only produce further vasoconstriction. The logical treatment in such a case would be to give intravenous hydrocorisone along with other supportive measures used in the treatment of shock and to rub the body surface to promote vasodilation mechanically, cooling the body surface only when and only where it becomes warm. In heat stroke, as long as the body surface remains warm, radical hypothermic measures may be employed. There seems to be no logical reason for giving hydrocortisone in heat stroke and, as a matter of fact, it has been tried apparently without beneficial effect.

Temperature disturbances caused by chronic lesions of the hypothalamus are rare but do occur, as noted in the following case:

A 40-year-old woman was sent to the University Hospital for treatment of a fever of unexplained origin. She was observed for eleven weeks during which time every conceivable test was carried out in an effort to complete a diagnosis. During the eleven weeks a septic type of fever continued in spite of antibiotics. The patient became increasingly disoriented, continuously gained weight, and developed attacks of Raynaud's Syndrome. Despite negative neurological findings and normal x-ray studies, the diagnosis of an anterior hypothalamic tumor was made and this diagnosis was confirmed at the postmortem examination. There were no other findings brought to light by the autopsy which could have accounted for this long continued temperature disturbance.

It is well known that temperature disturbances almost invariably follow complete lesions of the cervical spinal cord, particularly in hot weather. This is because there is damage to the hypothalamo-reticulospinal tracts ending around preganglionic neurons in the spinal cord. These tracts lead from temperature centers[1] in the hypothalamus and brain stem to the cell bodies of the intermediolateral column of the thoracic spinal cord which give rise to the preganglionic sympathetic system the postganglionic fibers of which control sweating and vasoconstriction. Though sweating will eventually return in complete lesions of the cervical spinal cord, since the postganglionic fibers are intact, there is always absence of sweating at first.

It is not so well known that severe temperature disturbances may be caused by lesions which do not affect the anterior hypothalamic area which protects against heat, or the posterior hypothalamic area which is believed to protect against cold, but by involvement of the tracts descending in the caudal hypothalamus or brain stem from these centers.

A 32-year-old woman[4] was operated upon with removal of a huge midline aneurysm which arose from the left carotid artery but was suprasellar in position. Four weeks after a stormy convalescence, a rectal temperature of 95° F. was recorded. For five weeks, with the exception of three temperatures recorded at 97.6° F., 95.6° F., and 95.0° F., there were no recordings about 94.4° F. The temperature was as low at 92° F. During this time, the patient was able to be up and around the ward making beds. No evidence of sweating was obtained from dermometer studies, and the temperature of the calf measured exactly the same as that of the toe, the usual temperature gradient being absent. The temperature of the left great toe was 31.8° C. (89.2° F.) in a cold room, 32.0° C. (89.6° F.) in a warm room. Since maximum vasodilatation of digits normally gives rise to a temperature of 33.5° C. (92.3° F.), this patient was functioning at the level of almost maximum vasodilatation of the lower extremities under different environmental conditions.

Felder et al,[5] in 1954, studied the relationship of skin temperature of the toes to blood flow as measured by the plethysmograph. They concluded that at room temperature of 20.5°C. + 2°C. (68.9°F.), it appears appropriate for clinical purposes to convert relatively constant skin temperature of a toe to volume blood flow per unit time. According to their studies, a constant skin temperature of 24°C. indicates a blood flow of 3 ml./100 ml./min.; a skin temperature of 29°C. indicates a blood flow of 10 ml./100 ml./min.; and a skin temperature of 32°C., a flow in excess of 30 ml./100 ml./min. Since the normal temperature of the toes is around 21°C., we estimate that during our patient's period of hypothermia the blood flow to the toes was more than ten times that found in the normal individual. When one considers that the temperature of the calf was 32°C., whereas that of the normal approximates 26°C., the fact of increased surface blood flow to the lower extremities is apparent. I believe, therefore, that the reason our patient

was hypothermic was because her extremities were acting as huge uncontrolled radiators.

When this patient[4] was given aspirin and hot drinks and was placed in a hot air bake, the mouth temperature rose 7° F. from 93.2° F. (34.0° C.) to 100.2° F. (37.9° C.) in three hours. Our patient, therefore, lacked control against heat as well as cold; and when her body was placed in the high environmental temperature of the bake, the dilated surface vessels absorbed heat into the blood stream and the cooling effect of sweating was absent as well. This patient, then, had true poikilothermia probably not derived from a lesion of the hypothalamic temperature centers but rather from the involvement of tracts arising from these centers.

This patient later developed normal temperature control. It is my opinion, however, that had she been subjected to an environmental temperature of 110° F. for some time while she was poikilothermic, the circulating blood would have reached a temperature of 110° F., and with the subsequent effect on the brain she would have developed a syndrome of heat stroke with its convulsions, coma, and death. In this case, the loss of the protective action of sweating would have had a central or hypothalamic origin since there would have been no exhaustion of the sweat glands.

It is now well known that heat exhaustion and heat stroke are two entirely different clinical syndromes. The early stage of heat exhaustion is manifested by muscular cramps. As the condition progresses, loss of appetite, weakness and fatigue develop; the pulse is rapid, the blood pressure is low, and, most important of all, in the differential diagnosis from heat stroke, the skin is cold and clammy and the body temperature ordinarily is not elevated. Heat exhaustion resembles shock and is caused mainly by loss of sodium chloride through excessive sweating. The treatment, of course, is intravenous sodium chloride.

Heat stroke, as a rule, comes on quite suddenly, accompanied by mental excitement and delirium, and the patient passes rapidly into a state of unconsciousness. The skin is absolutely dry and burning hot and has a florid appearance. Generalized convulsions are almost always present; petechial hemorrhages of the skin develop along with subconjunctival hemorrhages probably resulting from an increase in capillary fragility. I did not observe, however, in the cases I saw, any retinal hemorrhages.

A great deal was learned about heat stroke in Mesopotamia during the first World War. A classical paper by Hearne,[6] published in 1932, will be quoted extensively. Apparently, the lessons learned in Mesopotamia were either overlooked or forgotten at the outbreak of the second World War.

Hearne's interesting article states that in 1776 and 1777, Dr. George Fordyce and Dr. Blagden exposed themselves to dry and moist heat in a specially prepared room. They found that they could remain in a dry temperature at 260°F. without apparent discomfort or rise in body temperature for 13 minutes, while a "beefsteak was well cooked and eggs were roasted hard." Exposure to a moist temperature at 130°F. for a quarter of an hour caused a rise to 100°F. in mouth and urine temperature. Fordyce and Blagden's conclusions were that "if the air be moist as well as hot," evaporation of sweat cannot proceed rapidly enough to prevent the body temperature from rising.

According to Dr. J. Crocker,[7] 1st Lieutenant, Air Force, normal individuals have been subjected to even higher temperatures at the Environmental Section of the Aeronautical Laboratory at Dayton, Ohio. The subjects sat upon a chair in a 4-foot cube, in which the temperature of the wall was raised 100°F. per minute. The subject can ordinarily stay in the cube for 12 minutes at 350°F. If the individual is precooled so that his normal rectal temperature has been lowered, he can remain in the cube for 25 minutes without difficulty. The subject exhibits a marked blushing of the face and profuse diaphoresis almost immediately. It is the belief of the Air Force workers that what protects the individual is a fine film of moisture which he develops. They have kept subjects in the cube at temperatures as high as 400° F. for from six to eight minutes.

Hearne,[6] himself, saw 240 cases of heat stroke in his two-year service in Mesopotamia. At the Basra base alone, 44 cases occurred in one day. It was Hearne's conclusion that heat stroke is absolutely preventable. Suppression of perspiration provides the most reliable premonitory sign of impending heat stroke. Where great danger of heat stroke existed, hourly inspections of the men were carried out by Hearne or a trained orderly with palpation of the skin. If perspiration had ceased, cooling methods were applied and moisture was supplied to the skin surface as a replacement for the perspiration.

It was Hearne's stated belief in 1932 that "the essential cause of heat stroke is the suppression of perspiration which invariably precedes the attack for a more or less considerable time. There is no surface moisture available for evaporation; hence the body is not only deprived of its power to lose internally produced heat but actually gains heat from the surrounding atmosphere which may be 30°F. to 40°F. higher than the normal body temperature. The brain and tissues rapidly become superheated, resulting in typical convulsions, coma and death, if the patient be not subjected to early treatment." Hearne cites the

following case which makes it appear certain to him that the convulsions and unconsciousness are the direct result of the action of superheated blood on the brain and I am certain that this is true. He states that he had had a similar experience on seven or eight occasions:

A man walked to a "treatment area" asking that he be examined because he was not feeling well. He had the typical hot, dry, skin of oncoming heat stroke but he was conscious. While his temperature was being taken he began to grind his teeth on the thermometer. Shortly afterwards, he commenced to shout, struggle violently, and became unconscious. The mouth temperature, which had just been taken, was 108.6°F. Cooling measures, "cold water, ice, and electric fan," were immediately applied and within fifteen minutes the temperature had fallen to 104.8°F. Shortly afterward, he was answering questions intelligently. The patient made a complete recovery. Hearne attributed the failure of sweating to an exhaustion of the sweat glands brought about by several previous days of extreme hyperactivity of those glands.

In ten cases of heat stroke, .013 gm. (1/5 gr.) of Pilocarpine was given subcutaneously. Not a trace of perspiration could be obtained though the salivary glands responded with profuse salivation. It was Hearne's belief that the salivary apparatus remained intact because it had not been subjected to any previous overstrain.

Bannister[8] has recently described twelve cases of what he terms "acute anhydrotic heat exhaustion" which he observed in Aden. In these cases there was cessation of sweating without the accepted signs of heatstroke. All of the patients were incompletely acclimatized. In all cases the skin was hot, flushed, and dry. These patients were incapable of physical exertion. Their body temperatures ranged from 99.2° to 102°F.

Eleven of these patients were seen during a period from September 8 to 28. The mean morning shade temperatures during the hours when these soldiers worked were dry bulb, 93°F., and wet bulb, 82°F. I am certain that with this high humidity, exhaustion of the sweat glands developed. Heatstroke, which was rarely seen in Aden, did not develop since the environmental temperature was still lower than the body temperature, and heat loss could still take place by radiation, convection, and vaporization of water from the lungs.

Wolkin et al[9] described eight patients from an Army camp in Louisiana who, after exposure to excessive heat, ceased sweating over the entire body except on the face and neck. Pilocarpine and mecholyl parenterally failed to produce sweating over the anhydrotic area. The investigators attributed this sweating loss to a direct action of heat on the sweat glands. It was their opinion that were the sweating loss caused by a disturbance of the hypothalamic temperature regulating center, which they believed to be the case in true heat stroke, sweating would not have taken place on the face and neck. It is my opinion that had the patients of Wolkin et al developed anhydrosis over the face and neck, as they did over their bodies, they would have developed true heat stroke. Heat stroke in that hypothetical case then would have resulted from a direct action on the sweat glands rather than from hypothalamic disturbance.

Wolkin et al made the statement that "pilocarpine and mecholyl failed to produce a peripheral stimulation of sweating even in the presence of known central damage; namely, postoperative cerebral hyperthermia, heat stroke and thyroid crisis." They attributed the lack of sweating in heat stroke to a central cause and stated that in such cases "the lack of response of cholinergic drugs may be viewed as being the result of an active central inhibition strong enough to counteract the effect of these drugs."

Wolkin et al may be right in their belief that in the high temperatures of hypothalamic disturbance there may be a strong inhibition of the sweat glands. We have recently injected mecholyl intradermally after the method of Thaysen and Schwartz[10] in patients with high central temperatures. Local sweating did not develop, much to our surprise, in spite of the fact that there was no exhaustion of the sweat glands, whose postganglionic sympathetic fibers were still intact. Further work must be carried out before a definite statement can be made. A central inhibition of sweating need not be postulated, however, in the etiology of the ordinary clinical syndrome of heat stroke, though patients on whom operations have been carried out, which involve the hypothalamus, may actually die of "heat stroke" because of the effect of superheated blood on the brain.

In unacclimated individuals, the rate of sweat secretion has been shown to decrease during prolonged exposure to heat. Thaysen and Schwartz[10] have thrown light on the problem as to whether such a decrease in sweating rate is caused by failure of the sudomotor center (hypothalamus) or by exhaustion of the sweat glands. Thaysen and Schwartz showed that in normal subjects repeated intradermal injections or a constant intradermal infusion of mecholyl

evoked decreasing outputs of sweat until a refractory state was reached. The sweat glands which had been rendered refractory to mecholyl showed no response when the subject was then placed in a heating chamber and generalized reflex sweating was produced. On the other hand, with the subject in a heating chamber, the sweat glands of the forearm kept inactive by intradermal infusion of atropin for 4.8 hours showed a definite hypersecretion as compared with the glands on the other forearm when the atropin effect had worn off and the generalized heating continued. It was the opinion of these workers that fatigue of sweat glands and defective restoration of secretory activity after prolonged reflex sweating may be the primary factor in the etiology of heat stroke. This had also been the opinion of Hearne.

There appears to be little doubt that heat stroke is a symptom complex which may originate as cortical irritation followed by necrosis of cortical cells, when blood of a temperature between 107°F. to 111°F. circulates through the brain for a period of time. This overheating of the blood occurs as a rule at high environmental temperatures when there is failure of the sweating mechanism, although it may occasionally result from the high temperature of rheumatic fever, thyroid crisis, artificial hyperthermia or after cranial operations. In ordinary heat stroke the hypothalamus need not be blamed for the failure of the sweating mechanism.

In a study of approximately 40 brains from fetal cases of heat stroke, Malamud,[11] Haymaker and Custer stated that like other portions of the brain, the hypothalamic nuclei were subject to edema when the patient died early in the course of the disease; but that there were no significant changes in the hypothalamus of those who died later. This surprising immunity of the hypothalamus contrasts itself to the severe changes in the cerebral cortex and in the cerebellum in particular. "When survival was more than 24 hours, there was almost complete degeneration of the Purkinje layer and gliosis of corresponding severity." Their finding of the severest damage to the cerebellum is borne out by the clinical observation that when a neurological defect is a residual of heat stroke, it is usually in the cerebellar sphere.

Summary

The high temperatures which occur following operations in the region of the hypothalamus and the high temperatures of heat stroke arise from different mechanisms. The high temperatures which follow operative procedures arise from interference with the hypothalamic centers which protect against heat and from associated vascular collapse where the blood cannot adequately reach the periphery in order to give off heat. Hydrocortisone and measures directed against shock as a rule protect against this type of temperature disturbance.

Heat stroke with its delirium, convulsions, coma and death results from over heating of the brain secondary to an exhaustion of the sweating mechanism in extremely hot weather in unacclimatized individuals.[12,13] Changes in electrolytes, increased metabolism and circulatory failure are but secondary phenomena of heat stroke.

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Our Most Important Product

The satisfaction with which we view the decline in incidence of serious crippling disorders of the musculo-skeltal system is diminished by the appreciation of the unsolved problems which confront us.

We remember that the major contributions to our specific specialty were rendered by a host of medical workers in the laboratory and fields of medicine, apparently remote to orthopaedics.

The orthopaedic surgeon has come a long way from his original role as a straightener of crooked spines and deformed extremities and has emerged as a man of science and a physician. Our predecessors transcended their ignoble role of bone setters, plasterers, and surgical technicians by fostering research and education, increasing the originally narrow and limited field of their activities.

A review of current orthopaedic literature will demonstrate writings in such diverse subjects as radioactive isotopes, metabolism, pathologic physiology, and genetics. An academic aura surrounds us which is quite impressive, but a fundamental truth must be remembered. The ultimate consumer of our product is the oft-forgotten individual, the patient.

While some research work may have little or no clinical application by itself—the sum total of these isolated observations may ultimately produce the key which will unlock the door of another medical mystery.

Osteoporosis is just such a problem. A recent issue of a journal was devoted entirely to this subject. There are well-established causes of this disorder, mostly metabolic and endocrine. But the true nature of its cause remains a mystery. From a practical standpoint, the greatest incidence occurs in the post-menopausal female. The disease is insidious in its onset, with the first indication of trouble being pain usually in the dorsal and lumbar spine and spontaneous fractures are common. While the deformities in this region are amenable to treatment by support and bracing, and fractures in the area of the hip are amenable to internal fixation or replacement prosthesis, the process is unchanged in its course. Investigators have noted the efficacy of male or female hormones to ameliorate the symptoms. The 17-hydroxy-corticosteroids was felt to be a common denominator in this condition.

From the pathologic physiology it was established that the calcium left the osseous elements due to a loss of protein in the matrix of the bone. The crux of the matter was a negative nitrogen balance and if allowed to continue, the calcium had no place to deposit and the ultimate result was a negative calcium balance. Oddly enough, most laboratory studies involving the minerals of blood are within normal limits. The implication then is clear that the changes of senility and involution probably involve all the parenchymatous

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organs and tissues equally but that the cellular metabilsm of bone is hit the hardest.

These miracles of medicine have produced an artificial longevity, and with the increase in the number of older people, more osteoporosis will be encountered. Since there is no scientific cure, we must be physicians and treat them symptomatically. The *patient* is our most important product.

JAMES J. HORVATH, M.D.

AMA Program Positive? Yes!

All of us have heard the question raised whether the AMA has a "positive" program for the aged.

The question was answered in a "positive" manner by E. B. Howard, M.D., Chicago, in his address to the recent "MSMS Annual Seminar on Community Relations" for component society leaders. Doctor Howard is the assistant executive vice-president of the AMA.

Doctor Howard reported to Michigan doctors at the Seminar, "Many of you say we should be more positive, what are we for? I would like to point out why our program is so positive. It is constructive, progressive, forward-looking, moving with the future, into 'new frontiers' if you will. It is a good program in that true sense. It isn't reactionary and backward-looking. We're for helping the needy through improved OAA and through improved AMA programs, and we supported that throughout this aid to the aged controversy."

The AMA official also stressed the point that "Medicine is for helping voluntary enterprise through the Blues, and through health insurance policies of various kinds, through improved economic status, through anti-inflationary measures for those who are solvent. This is a wholly positive program."

Doctor Howard paid tribute to Frederick C. Swartz, M.D., of Lansing. He declared "We're for the wonderful program that the AMA's Committee on Aging —your own Dr. Swartz is Chairman—has put out over the last 8 years. And you may have seen some of the fine publicity that that committee received after its report in Los Angeles at the AMA meeting last month. Here is a fully positive point of view and posture. It is obvious that what the aged must have to continue to be self-reliant is a climate in which they can produce. This means flexible retirement, and so AMA has fought actively for non-mandatory retirement programs. This is a fundamental positive point in our program for the aged, because if the future aged of our nation—and we may have many more aged if we make the advances that we hope for against cancer and heart disease—but if those aged are to remain productive, if they are to be taken off the backs of the young taxpayers of the nation whose total number is expected to be much smaller percentage-wise in the next 10 years, then they must be provided a climate in which they can be productive. Flexible retirement is a most important item in their positive program. And flexible retirement carries within it the idea of change from one job to another, change of responsibility from a top job at the age of 60 to a lesser job but still a productive one, at a later age, a job commensurate with the abilities and intellectual status of the person."



DOCTOR HOWARD ADDRESSES MSMS SEMINAR.

The Michigan doctors heard some first-hand observations about AMA legislaive efforts. Doctor Howard emphasized, "We have also supported in our positive program measures both legislative and otherwise to improve the facilities of our aged. We recognize that hospitals alone are not designed in many instances to care for the kind of long-term chronic illness, with intermittent ambulatory care, and that nursing homes of various types are an urgent need in their whole positive program. AMA supported strongly the Hill-Burton Amendment two years ago to provide funds for additional Hill-Burton installations of a nursing home type, and also suggested and pushed the amendment in Congress which Representative Tom Curtis proposed for government guaranteed loans for proprietory nursing homes. So that these two measures, one designed to promote further con-

struction of non-proprietory homes and the other to promote construction of the profit-type, were both supported strongly by the AMA."

Doctor Howard said it was not enough to have a positive program but that doctors must "push our positive programs."

The speaker singled out two positive programs that need and merit special attention. These are the (1) medical aid to aged programs under the Kerr-Mills Law, and the (2) prepayment protection offered by health insurance firms and by the Blues.

In summarizing the AMA program for the aged, Doctor Howard said:

"We are on record as wanting to help the needy and as believing voluntary enterprise can effectively serve the non-needy who are solvent and can take care of themselves.

"This AMA two-headed program is completely sensible, realistic, intelligent—and positive."

Doctor, Tell the Story!

The Medical Aid to the Aged (MAA) program in Michigan provides far more complete medical care for the needy than the proposed Kennedy schemes tied to Social Security financing.

In Michigan, the Medical Aid to the Aged (MAA) program now in its third year provides complete aid to those who meet liberal qualifications. Contrast the excellent Michigan program (M-75 medical benefits, comprehensive hospital benefits) with the "best" of the socialized medicine schemes in Washington, which provide for only about 35 per cent of the actual health care needs of the aged!

This fact generally is not known by Michigan voters and taxpayers. Michigan doctors, who supported passage of the MAA Law in Michigan, must tell this story more effectively.

During 1963 additional state legislatures throughout the country will adopt, or improve upon existing, programs under the Kerr-Mills Law which provides federal financial assistance for locally determined, locally administered and locally controlled voluntary medical aid programs.

Representative Wilbur D. Mills, co-sponsor of the Kerr-Mills Law, reports 32 states now offering MAA care. He states that the number of persons receiving MAA aid increased from 64,594 in January of 1962 to 105,217 in September of 1962.

It appears that a modified version of the Anderson-Javits bill, rejected by the Congress last year, will be fielded by the Administration in the 88th Congress. The Anderson-Javits bill, of course, was the modification of the King-Anderson bill. But no matter what the modification, one thing is certain—the Administration's proposal will be tied to the Social Security method of financing and will therefore be a massive, compulsory system to cover all, regardless of need, with federally controlled medical care.

Kerr-Mills, fully utilized and administered by those who want the program to work, can do the total job. Throughout our own state, where there is a desire to make MAA work, we are proving this to be true. We must do a continually better job. And tell the people about it.

The Kind of People in Medicine

Many delegates at the interim meeting of the AMA House of Delegates were impressed with the views expressed by James A. Brooks, SAMA representative in medical training at the University of Oregon.

Young student Brooks said:

"We can all agree that your aim and mine is to provide for the best possible medical care for the public. We also agree that this can only be done by having physicians who value free choice and individual initiative, retaining the qualities in our doctors that make medicine what it is in the United States."

He continued:

"We all talk about free enterprise, individual initiative and a free system of medicine when what we're really talking about is the kind of people in medicine. Not perfect by any means, but intelligent, individualistic, ethical, hard-working persons who are not afraid of work and enjoy the security of depending on their own ability to make decisions and accept responsibility. This type of person, the men in medicine today and yesterday, are the reason American medicine is what it is."

Gives Five Health Tips

In a paper given at the AMA Committee on Aging Conference in Buffalo, five things were cited as necessary to maintain good health throughout a lifetime.

These are a well-balanced diet, regular exercise, enough rest, regular health check-ups and supervision, and continuing sources of emotional and creative satisfaction.

Of the last item, the Committee said that a sense of purpose of contribution to the human community is as vital to total health as are adequate nutrition and rest.

Michigan State Medical Society

Annual Meeting of The Council

January 25-26, 1963

HIGHLIGHTS

Twenty-two of the twenty-four members of The Council attended the 1963 annual meeting which extended over a period of two and one-half days. Guests included E. B. Howard, M.D., of Chicago, Assistant Executive Vice President of AMA; Sidney Adler, M.D., Sumner G. Whittier, J. E. Verbiest, and Neal McCue of Michigan Medical Service; Wm. S. McNary, President Michigan Hospital Service; A. E. Heustis, M.D., Michigan Commissioner of Health; Kenneth H. Johnson, M.D., Advisor to Building Committee; C. J. Tupper, M.D., Assistant Dean, UM Medical School; C. T. Hardwick, Ph.D., MSMS Economic Consultant and Richard M. Canipau, MSMS Research Director and Wm. R. Ramsey, AMA Field Secretary.

Ninety-four (94) items were considered by The Council; chief in importance were:

- The Secretary's Annual Report was approved with thanks (see page 303).
- The Editor's Annual Report was approved with thanks (see page 305).
- Reports of the County Societies Committee, the Finance Committee, and the Publications Committee—Standing Committees of The Council—were approved as amended by the Reference Committees.
- The Auditor's Report for the year 1962, and the budgets for the year 1963 were thoroughly considered and approved.
- Elections. Secretary D. Bruce Wiley, M.D., of Utica, Treasurer Wm. A. Hyland, M.D., Grand Rapids, and Editor Wilfrid Haughey, M.D., of Battle Creek were re-elected for the year 1963. Wm. J. Burns was re-appointed as Executive Director.
- Progress report on Michigan Hospital Service (Blue Cross) was presented by Wm. S. McNary, President.
- Progress report on Michigan Medical Service (Blue Shield) was presented by President Adler and elaborated by Mr. Whittier.
- AMA Assistant Executive Vice-President Ernest B. Howard, M.D., discussed the progress of constituent state societies, the American Medical Association, and AMPAC.
- Committee Reports. The following were considered:

 (a) Legal Affairs Committee, meeting of January 3.

 THE COUNCIL ENDORSED THE UNANIMOUS RECOMMENDATION OF THE LEGAL AFFAIRS COMMITTEE THAT THE MICHIGAN STATE MEDICAL SOCIETY PUBLICLY SUPPORT THE PROPOSED MICHIGAN CONSTITUTION.

 (b) Disaster Medical Care Committee, November 28.

 (c) Mental Health Committee, December 4.

 (d) Committee on Professional Insurance Plans, December 5.

 (e) Committee on Professional Insurance Plans with Michigan Health Insurance Counsel, December 5.

 (f) Postgraduate Medical Education Committee, December 6.

 (g) Medical Care Insurance Committee, December 6.

(h) Occupational Health Committee, December 7.

(i) Ad Hoc Committee for Conferences of Health Care, December 6.

(j) Public Health Committee, December 13.

(k) Liaison Committee with Michigan Association of Osteopathic Physicians and Surgeons, December 16.

(l) Maternal Health Committee, January 10.

(m) Liaison Committee with State Executive Office, December 26 and January 6.

(n) Annual Session Program Committee, January 17.

The reports of two other committees, to which MSMS sends representatives, were presented.

(a) Michigan Cancer Coordinating Committee, January 10.

(b) Joint Council to Improve the Health Care of the Aged Nov. 29, 1962.

- A proposed "Agreement for the Operation of the Michigan Diabetes Program" was thoroughly discussed and referred to the County Societies Committee for further study and report.
- J. E. Livesay, M.D., Flint, was appointed to the MSMS Legal Affairs Committee by President C. I. Owen, M.D., of Detroit.
- Progress Report on AMA-ERF—Michigan contributions for September 1962 totaled $8,915, as reported by President-Elect O. J. Johnson, M.D., of Bay City.
- Social Security Poll. Speaker J. J. Lightbody, M.D., of Detroit reported that 4,700 replies had been received from members to January 24 and that on February 21, all replies received would be given to an outside service company for envelope opening and tabulation of certified returns.
- An invitation to co-sponsor a program on Diet Therapy, at the invitation of the Michigan Department of Health, was accepted with thanks.
- Carl B. Beeman, M.D., of Grand Rapids accepted appointment as General Chairman of Arrangements for the 1963 Annual Session September 25-26-27, 1963, Pantlind Hotel-Civic Auditorium, Grand Rapids.
- A first aid room has been set up in the Capitol at Lansing for members of the Michigan Legislature, according to report of Council Chairman Oliver B. McGillicuddy, M.D., of Lansing, Ingham County physicians will cooperate as they did so well in the Constitutional Convention first-aid room.
- Insurance Commissioner's Hearings on requested Blue Cross-Blue Shield rate increases in Detroit and Grand Rapids will be covered by MSMS representative O. K. Engelke, M.D., who will present briefs at both hearings.
- Wm. M. LeFevre, M.D., Muskegon, E. R. Elzinga, M.D., of Marquette and E. T. Palm, M.D., of Crystal Falls were nominated for vacancies on the Michigan Hospital Service Board of Trustees.
- Benjamin Jeffries, M.D., of Detroit, Chairman of the MSMS Mental Health Committee, was authorized to attend the Ninth Annual Conference of Mental Health Representatives of State Medical Associations in Chicago March 1 and 2, as MSMS representative; Louis F. Hayes, M.D., of Gaylord was authorized to attend the Third National Congress on Voluntary Insurance and Prepayment Plans February 15-16 Chicago, as MSMS representative; J. W. Rice, M.D., of Jackson, was authorized to attend the Congress on Medical Education February 2-5 Chicago as MSMS representative.
- Matters of mutual interest were presented by A. E. Heustis, M.D., Michigan Health Commissioner, including VD reporting, oral polio vaccine, budget requests, hospital licensing and four-way vaccine.

- Executive Director Wm. J. Burns reported 11 staff meetings held to aid communication among staff members and to develop better methods of handling the work load; 16 committee meetings and 6 other meetings throughout the state were covered by staff. Eight State Society Nights have been held or arranged (Mecosta-Osceola-Lake County Medical Society; North Central Medical Society; Oakland County Medical Society; Allegan County Medical Society; Jackson County Medical Society; Hillsdale County Medical Society; Macomb County Medical Society; and Monroe County Medical Society).
- The 1963 Michigan Clinical Institute program has been developed, with 86 speakers for the (a) 8:00 to 9:00 a.m. Clinical Round Tables (b) the five Assembly blocks and (c) the closed circuit color television program.
- Plans for the 1965 Centennial and Health Fair were outlined by Executive Director Burns.
- Legal Counsel Lester P. Dodd reported he examined and approved the proposed Articles of Incorporation for the Washtenaw County Medical Society, the Berrien County Medical Society and the Wexford-Missaukee County Medical Society; he rendered opinions re (a) membership in component society requiring membership in State Society; (b) re consent to operative procedure or anesthesia in cases involving minors; he advised a county medical society re its problems in a local hospital; he advised concerning "Statement of Principles Governing Hospitals, Lawyers, and Doctors"; and on the Organization and Incorporation of the Michigan Health Fair.
- Public Relations Counsel H. W. Brenneman reported on the program of the Congress of the Professions, meeting in Lansing February 9-10.
- Duties of the Secretary. The Council, in accordance with action of the 1962 MSMS House of Delegates, ruled that the duties of the Secretary be transferred to the Executive Director, and further that the Executive Director shall be the administrative officer of the staff responsible to The Council.
 The Chairman of The Council was authorized to appoint an Ad Hoc Planning Committee on Headquarters Organization.
- The Council urged the reappointment of A. E. Heustis, M.D., as Michigan State Health Commissioner and further that his salary be substantially increased.
- The Publication Committee requested the appointment of a Subcommittee to re-evaluate (a) the present practice of designating special issues of The Journal each month and (b) the present content of The Journal. The Committee also limited bibliography to the printing of 6 references for any one scientific paper; it also ruled that hereafter, The Journal cover (without art work) be designed to include the nameplate, a listing of selected scientific articles in that issue, a listing of some important MSMS activities described in that issue, and a listing of some socio-economic articles in that issue, this to take effect immediately; it deleted the printed list of committees which in future are to be mimeographed.
- The Finance Committee approved bills payable for December 1962; it recommended that a financial report from Michigan Association of the Professions for 1962 and successive years be requested by The Council; it reviewed executive staff salaries and recommended five adjustments; it referred Mr. Burns' retirement status to Legal Counsel for review.
 The Finance Committee also recommended increasing financial support to the two SAMA Chapters in Michigan to $300.00 per annum. It also recommended membership in the Adult Education Association of Michigan, and in the Michigan School Health Association.
- The Council voted to create a contingency fund to be provided in the 1963 budget of $18,850, this to be placed in a savings account and be known as MSMS Savings Reserve.

- Four MSMS members questioned the $10.00 assessment for AMA-ERF (to be used by the two medical schools in Michigan) as adopted by the 1962 MSMS House of Delegates. The Council requested the Secretary to inform county societies that the assessment is levied within the stated purpose of the Society in accordance with the Bylaws, and payment of the assessment is required for membership.
- The Council reviewed the AMA House of Delegates "Study of Relations of Physicians Not-in-Private Practice to Organized Medicine" and felt there was no need for change in MSMS or component society bylaws or programs because present policies are now in line with the AMA recommendations; however, the desirability of certain doctors of medicine not licensed in Michigan becoming members of both MSMS and the component society was discussed with the result that a resolution will be presented to the 1963 MSMS House of Delegates to improve the opportunity.
- The County Societies Committee discussed the report of the Michigan Department of Health Plan for Executive Operation and viewed with alarm the apparent encroachment of public health into the field of private practice such as in (a) Chronic Disease Control (b) Cancer Control and (c) Heart Disease Control. The Council approved the action of the reference committee: the Legal Affairs Committee was instructed to consider the budget of the Michigan Department of Health in relation to areas of need. The Michigan Delegates to the AMA House of Delegates were requested to present a resolution at the next AMA meeting to more clearly define public health in relation to the private practice of medicine.
- The Council requested the Chairman of the Michigan Delegation of the AMA, and each individual AMA Delegate, to use their influence to increase the representation of Michigan doctors of medicine on the councils and committees of the AMA.

ANNUAL REPORT OF THE SECRETARY

Presented to The Council January 25, 1963

Membership

The Michigan State Medical Society membership for 1962 showed a total of 7,018 members, including 35 Military members, 363 Associate members, 415 Life members, 115 Retired members, 6 Honorary members, and two non-residents.

The total paid membership was 6,082, with net dues of $465,682.06. The number of members with unpaid dues was 33. (The 1961 totals were 5,939 paid members and 30 unpaid.)

Deaths During 1962

I must regretfully report a total of 87 deaths among members during 1962:

Barry County—E. T. Morris, M.D., Nashville, Michigan.

Chippewa-Mackinac County—Irene Gates, M.D., Mackinac Island, Michigan

Eaton County—Edgar F. Imthun, M.D., Grand Ledge, Michigan.

Genesee County—Barney A. Credille, M.D., Flint, Michigan; Edwin G. Dimond, M.D., Flint, Michigan; Donald R. Grady, M.D., Flint, Michigan; Burton G. McGarry, M.D., Howell, Michigan; Oscar W. McKenna, M.D., Flint, Michigan; Herbert T. White, M.D., Flint, Michigan.

Gogebic County—Theodore J. Keskey, M.D., Ironwood.

Houghton County—Charles R. Smith, M.D., Hancock

Ingham County—Leo G. Christian, M.D., Lansing; Emily R. Hautau, M.D., East Lansing; Elmer G. McConnell, M.D., Lansing; John Reid, East Lansing (Honorary Member).

Jackson County—Wm. L. Foust, M.D., Grass Lake; W. B. Huntley, M.D., St. Petersburg, Florida; Lewis L. Stewart, M.D., Jackson.

Kalamazoo County—Earl L. Burbidge, M.D., Parchment; Warren B. Crane, M.D., Kalamazoo; Merle R. French, M.D., Kalamazoo; Clark B. Fulkerson, M.D., Vicksburg; James W. McManus, M.D., Kalamazoo; Dirk J. Scholten, M.D., Kalamazoo.

Kent County—Leon C. Bosch, M.D., Grand Rapids; Robert H. Denham, M.D., Grand Rapids; Alexander M. Martin, M.D., Grand Rapids; Glenn A. Pearson, M.D., Grand Rapids; Ansel B. Smith, M.D., Grand Rapids; Arthur Van Solkema, M.D., Grandville.

Lapeer County—Harry B. Zemmer, M.D., Lapeer.

Livingston County—Walter E. Green, M.D., Detroit; Archie J. McGregor, M.D., Brighton; Hollis L. Sigler, M.D., Howell.

Macomb County—Milo J. Brady, M.D., St. Clair Shores.

Mecosta-Osceola-Lake County—Leo F. Chess, M.D., Reed City; Thomas P. Treynor, M.D., Big Rapids.

Menominee County—Clarence E. Flanagan, M.D., Menominee.

Monroe County—Emerson J. J. Sanger, M.D., Monroe.

North Central Counties—Joseph L. Egle, M.D., Gaylord; George W. Palm, M.D., Swartz Creek.

Northern Michigan Counties—Roy W. Hodges, M.D., Mackinac City.

Oakland County—Charles M. Burgess, M.D., Ferndale; M. E. Christopher, M.D., Detroit; George C. Hardy, M.D., Rochester; Norman O. Lamarche, M.D., Berkley; Lionel N. Merrill, M.D., Royal Oak; Albert C. Wilson, M.D., Birmingham.

Saginaw County—Ernest M. Ling, M.D., Spring Lake; Frank W. Ostrander, M.D., Freeland.

St. Clair County—George Van Rhee, M.D., Port Huron.

Washtenaw County—Glendon T. Clements, M.D., Chelsea.

Wayne County—George H. Andries, M.D., Detroit; Bruno B. Brunke, M.D., Detroit; Albert E. Catherwood, M.D., Detroit; Harry G. Clark, M.D., Gallipolis, Ohio; M. E. Danforth, M.D., Detroit; John F. Demaray, M.D., Detroit; Victor Droock, M.D., Detroit; Clayton J. Ettinger, M.D., Highland Park; Leland S. Evans, M.D., Detroit; Rubie R. Goldstone, M.D., Detroit; Frederick D. Goudie, M.D., Lathrup Village; Julius A. Graham, M.D., Detroit; Norman K. H'Amada, M.D., Detroit; Harry Hirt, M.D., Detroit; Willard B. Howes, M.D., Royal Oak; Vincent C. Johnson, M.D., Grosse Pointe Shores; Harther L. Keim, M.D., Detroit; Sarkis K. Keshishian, M.D., Highland Park; H. M. Kyprie, M.D. Southfield; Charles J. Lilly, M.D., Detroit; Abraham R. Lincoln, M.D., Detroit; Elbert A. Martin, M.D., Detroit; Frederick T. May, M.D., Detroit; Plinn F. Morse, M.D., Detroit; Leo P. Rennell, M.D., Detroit; Theodore I. Roth, M.D., Detroit; David J. Sandweiss, M.D., Detroit; James W. Sinclair, M.D., Detroit; Robert R. Sterling, M.D., Birmingham; Thomas O. Stewart, M.D., Detroit; William M. Tuttle, M.D., Detroit; Henry L. Ulbrich, M.D., Grosse Pointe Woods; Alger F. VanHoey, M.D., Detroit; Robert A. C. Wollenberg, M.D., Detroit; Fred B. Wight, M.D., St. Clair Shores.

Organizational Activities

1962 Annual Session: Held in Detroit, the 97th Annual Session drew a total of 3,412, which included 2,184 doctors of medicine. A number of refinements were made in the scientific program, which continues to prove popular and valuable to MSMS members and guests.

1962 Michigan Clinical Institute: Once again, many groups joined to sponsor this spring postgraduate program. The 16th Michigan Clinical Institute drew 2,195, including 1,035 doctors, to Detroit. The evening seminars and the early morning discussion groups proved popular and will become part of the 1963 Institute.

Annual County Secretaries-Public Relations Seminar: The Seminar was held at the Kellogg Center and highlighted speakers and panels on various socio-economic aspects of medicine. At the close of the day-long seminar, the participants were invited to tour the MSMS Headquarters. Total attendance was 119.

The Journal

The Editor has prepared, as in the past, his annual report. The report appears elsewhere in this number of The Journal MSMS.

Finances

An audit of the MSMS finances covering 12 months was completed by Auditor Kenneth B. Knostman, CPA, as of November 30, 1962. This has been submitted to the Finance Committee of The Council for study and is available to any member of the Society for perusal at the MSMS Headquarters, 120 West Saginaw, East Lansing, Michigan.

Public Relations

The Public Relations program and its implementation has been extensively reviewed in both the Report of The Council to the House of Delegates and in the Annual Report of the Public Relations Committee. The House took occasion to specifically commend the work done. Public Relations activities have been well rounded in nature, combining effectively the use of radio, TV, newspapers, motion pictures, publications, exhibits, conferences, speakers, et cetera.

1. I invite your attention now to highlights worthy of particular note: The principles established by The Council and the House of Delegates in the President's Program have served the Society well in the subject areas of the resolution and very well from the standpoint of public relations. They have been repeatedly reiterated and in each instance they have been well received. As we move toward the celebration of the MSMS centennial in 1965 it is important that these programs continue to be implemented so that not only will they have served their individual purposes but also that we might point with pride to their success.

2. A truly superb campaign was carried out in support of the principles espoused in our legislative efforts in both the state legislature and national congress. It should be noted that one of the most valuable portions of this work was the establishment and re-establishment of close liaison with the allied groups representative of farming, industry, business, insurance, and particularly with other professions.

3. Our efforts have borne fruit in the establishment of the Michigan Association of the Professions which now comprises eight professions having in their total membership 89,000 professional people. MAP is supported by a membership of approximately 4,000 individual members and the work it is doing, particularly in presenting the television program, DECISIONS, in the distribution of its Journal, and in the planning of its Congress (annual meeting), has been effective in interpreting, for both public and professional relations purposes, the medical profession in the finest light.

4. I again invite your attention to the fact that the Michigan Health Council has constituted a very valuable source of good public relations and our participation in it has proven valuable toward the support of the voluntary concept of health and medical care.

May we emphasize again the necessity in all actions of the Medical Society to demonstrate the concern of the organized medical profession for the public welfare. Just as we as individual doctors have as our primary objective the health of our patients, so the MSMS and its component societies must demonstrably have the good health of the public as their primary objective. Toward these ends the Public Relations Committee has made several recommendations of which The Council is aware and which will be considered by it in the formulation of the 1963 budget.

We must recognize that legislative and political efforts are important but in doing so we must not forget that legislative strength is the end result of having both a general atmosphere of approval of our work on the part of the public and a reservoir of friends upon which we can call for support. To maintain these two things requires efforts to establish the proper public image of the profession quite apart from specific political work.

Committees

A total of 705 MSMS members gave unselfishly of their abilities and time to study problems and to develop workable solutions. These members served on 68 different committees, which held a total of 103 meetings. Virtually all of these meetings were covered by MSMS staff personnel.

Much credit and commendation must go to these MSMS committee members, who formulate and carry out the activities in accordance with instructions from the MSMS House of Delegates and The Council

Services for Members

1. *Group Life Insurance:* Our group life insurance carrier, Mutual Benefit Life Insurance Company of New Jersey, reports that 1,542 members are now insured. The total amount of insurance in force is $13,125,000. The firm reports that during 1962, premiums collected amounted to $107,500. Claims paid totaled $66,500, with claims of $6,000 now pending. The plan has paid a total of $244,000 since it started. The firm also reports that there are six members now under waiver of premiums for disability, insured for an aggregate of $43,500. As authorized by the 1962 House of Delegates, a new supplemental term life insurance plan is being offered to MSMS members. It is contemplated that this plan will become effective February 1, 1963.

2. *Group Health and Accident Insurance:* The Provident Life & Accident Insurance Company, our carrier, reports a current enrollment of 2,050. During 1962, claim payments amounted to $132,150.56. A total of 317 new claims was reported in 1962. At the close of 1962 there were 55 open claims. The reserve on December, 1962 (representing future liability on present reported claims) was $109,626.73. The weekly disability benefit continues to be increased by 10 per cent in case of claim.

Legal Affairs

The holding of Michigan's first Constitutional Convention in more than fifty years added surveillance of the Convention's deliberations to both an unusually busy state legislative session and a major federal health care for the aged battle in Congress during 1962.

MSMS testimony and recommendations to the appropriate committees of the Constitutional Convention was instrumental in assuring that "health" references in the new document are properly constitutional; thanks to the support of all MSMS members and the understanding of Michigan's legislators 1962 was an extremely successful year in the State Legislature for the medical profession; and a magnificent effort on the part of Michigan doctors of medicine through all component societies played a significant part in the rejection by the 87th Congress of HR 4222, the King-Anderson bill.

It should be noted that the A.M.A. particularly singled out MSMS for its effective, highly concentrated campaign throughout 1962 in opposition to HR 4222. The House of Delegates of MSMS, in September, accorded a tribute to The Council, MSMS' President and the Legal Affairs Committee for their leadership during a critical period when legislation inimical to the best health interests of the American people was before the Congress.

More than 1,200 state legislative proposals were reviewed by the Legal Affairs Committee during 1962 in a six-month legislative session, highlighted by the passage of a professional incorporation statute and the tabling, for intensive study, of a proposal to create a new and powerful council to license and regulate all hospitals in Michigan.

During the legislative session, bi-weekly reports dealing in separate sections with state, national and Constitutional Convention matters, were issued to over 1,000 Michigan physicians so that all members could be currently informed about the wide range of proposals affecting the health care of the people. A wise Legislature passed no bills detrimental to the best health interest of the public and medicine.

Field services were again expanded during 1962 as MSMS Councilors and the headquarters staff brought timely and pertinent information to the Society's membership. The State Society is most grateful for the splendid cooperation and support of all members which was primarily instrumental in bringing about the highly successful legislative year just completed.

1962 House of Delegates

No detailed report of the 1962 House of Delegates is made by your Secretary because the full proceedings appear as part of the 1963 January Journal. An unofficial digest of the House actions was mailed in October to every member.

Medical Socio-Economics

The new Department of Medical Socio-Economics was established in 1961, as authorized by the House of Delegates, with the appointment on December 1, 1961, of Mr. Richard Campau as staff Research Director. Mr. Campau was an economist on the faculty of the University of Detroit. Also retained was Professor C. T. Hardwick, Ph.D., as MSMS Economic Consultant. Professor Hardwick is Director for the Institute for Business Services, University of Detroit.

The Department devoted a great deal of time preparing necessary material, presentations and testimony for the Hearings of the Governor's Commission on Prepaid Hospital and Medical Plans. The results of this research were utilized by Chairman Harold F. Falls, M.D., and MSMS officers, in testimony before the Commission.

The Department also assisted the Legal Affairs Committee with backup material during testimony before various Committees of the Michigan Legislature.

In addition, much individual help was provided to MSMS Committees and Officers engaged in specific functions requiring compilations of information and data, much of which required original research.

Communications With Members

Effective communication with the membership continues to be a major effort. Various channels are used to obtain the greatest results:

1. *Secretary's Letter*—During 1962, a total of three Letters was mailed to the leaders of the component societies, relaying pertinent information from the House of Delegates and The Council.

2. *MSMS Journal*—The State Society Section of the monthly Journal carried important news to all the members.

3. *MSMS Legislative Reports*—This special, timely newsletter is mailed during the legislative session to 964 key men.

4. *Research Bulletins* from MSMS Medical Socio-Economics Department—Four bulletins interpreted socio-economic data for the MSMS members vitally concerned with such matters.

5. *MSMS President's Letter*—The MSMS President corresponds at intervals with all the members on important organizational matters. Four issues were distributed in 1962.

6. *MSMS Annual Report*—A digest of the Annual Report was printed and mailed to every member in October, in an effort to keep the members better informed about society matters.

ACKNOWLEDGMENTS

Each member of the Executive Office staff continues to give untiringly of his time and abilities in behalf of the Michigan State Medical Society. MSMS indeed is fortunate to have such skilled and loyal employees. During 1962, three employees were honored for long service—Vada Davis, ten years; Mary K. Brewbaker, five years, and Delta M. Berry, five years.

To everyone who has aided so generously and willingly in the discharge of his duties, your Secretary is most grateful.

D. BRUCE WILEY, M.D.
Secretary

EDITOR'S REPORT FOR 1962

In 1962, we have continued the procedure established many years ago to assign certain Numbers of THE JOURNAL to certain interests, sections or activities of the Michigan State Medical Society. This program was established to overcome a very serious difficulty we were having in securing adequate papers for THE JOURNAL.

The present editor took over when the previous editor had been commissioned in the army and received sudden call to active duty. Being Chairman of the Publication Committee, I went to Muskegon and picked up the materials on hand so that there would be no break in the continuity. There were papers for the current and the next number of THE JOURNAL, but beyond that, only one original article on file.

We called on all of our friends and acquaintances, the administrative officers of the two medical schools, begging for original papers which could be used in THE JOURNAL. We also called upon county societies, especially the larger ones which might have such material, and we did succeed in running THE JOURNAL for awhile; however, it was always a contest.

A short time later we conceived the idea of publishing one Journal as a tribute to the University of Michigan Medical School. It was having a memorial date coming up and we asked them to supply papers for THE JOURNAL. The same thing occurred with Wayne State University Medical School. We also wrote to our friends on the faculty in the specialties who could give special articles and we built up a source of material.

We soon discovered, however, that there must be some continuity so we quietly offered to dedicate various numbers of THE JOURNAL to various county societies, areas and specialties. This has produced an abundance of material. We are continuing to follow this program and we believe that the material presented compares favorably with any other journal anywhere. Other state medical journals are having difficulty to fill their spaces. This is one of the chief questions at our yearly conferences of editors—how to secure adequate and sufficiently appropriate original articles for THE JOURNAL. A state medical journal must be a general journal, it must supply the wants and wishes of its readers and it must look to them for its materials very largely and it must in addition be strictly a house organ. It must speak for and to its membership. Its membership must contribute to its success and materials.

This last year has been a very special amplification of the value of this thought. Our issues of THE JOURNAL are planned in advance by previous solicitation from various groups, specialties and interests. Those for 1963 are already assigned and all but three are assigned for 1964. The December 1964 issue will be the introduction to the Centennial. It seems such a short time ago that we were talking easily of adding five useful years to our citizenship. Numbers of THE JOURNAL for the year 1963 are assigned as follows: *January*—Michigan Clinical Institute; *February*—Master Surgery (a combination of circumstances and a meeting of minds suggested this title and exposition on which some members have been working for a year; we are presenting five specially prepared and presented articles on reports and research with the concept that Michigan produces); *March*—Orthopedics; *April*—Cancer; *May*—Aging; *June*—Michigan Medical Service; *July*—Michigan State Medical Society Annual Session; *August*—Saginaw County Medical Society; *September*—Michigan Academy of General Practice; *October*—Alcoholism; *November*—Heart; *December*—Michigan State Medical Society and the Medical School Postgraduate programs.

During the year we have published 1571 pages and in January a 91-page supplement—the Proceedings of the House of Delegates which is getting constantly larger, and in February a supplement of the Committees which is getting smaller (12 pages). This year, we have had 215 original authors. In eight cases, two men cooperated, and in two cases, three men cooperated to produce papers. In our 215 original articles, there is really a very small amount of duplication, because of the fact that many men publish papers with others as co-authors.

During the year, we have urged our members to produce shorter papers because they are more apt to be read and considered than longer ones. This has proved out because there are quite a few more authors in that list than previously and the number of pages is almost the same. We produced 85 ancillary articles, 9 county society reports, 30 book reviews, 49 editorials and 22 editorial opinions, 7 heart beats, 77 obituaries including two former councillors, 12 letters to the editor.

The foresight and arrangements and assignments of materials we have been following for years was demonstrated of real value. The editor himself underwent serious surgery with a long continued convalescence but the program had been set up and the materials accumulated so that each month original articles were available, and some editorials were accumulated. We admit that particular problem worried us but we feel that is being handled in a satisfactory manner. At any rate it is being handled so that the casual observer would not notice much difference.

We thank our coordinators, our Chairman and our Publication Committee. We thank our headquarters office for a job extremely well done. As always it has been a great pleasure and satisfaction to work with The Council and the Publication Committee and to carry on this major project of the Michigan State Medical Society.

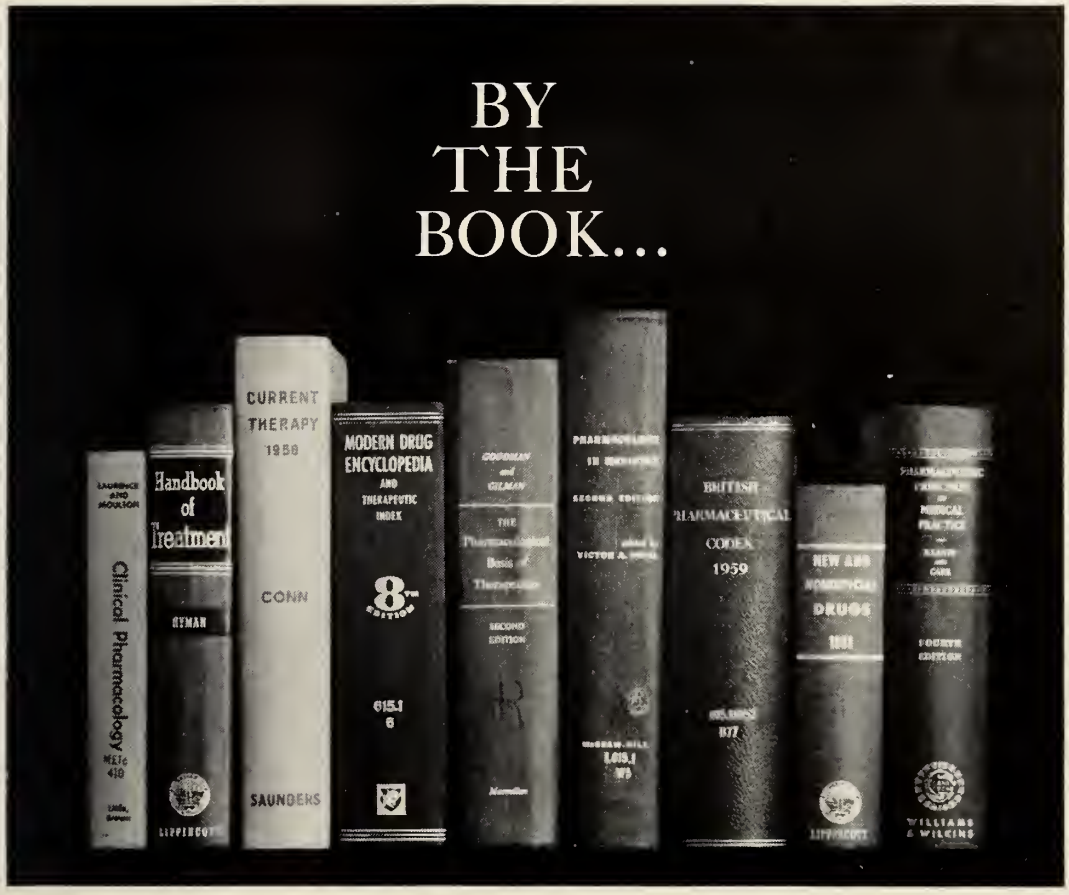
WILFRID HAUGHEY, M.D., *Editor*

WAYNE STATE ACCEPTING 2-4-2 MEDICAL APPLICATIONS

Inquiries regarding Wayne State University's 2-4-2 plan of the Colleges of Liberal Arts and Medicine can be directed to the College of Medicine, 1401 Rivard, Detroit 7, Michigan.

The first two years of the 2-4-2 plan may be completed at any accredited liberal arts or junior college. The next four years are divided between the WSU Colleges of Liberal Arts and Medicine. The final two years are spent in clinical training at the College of Medicine and its affiliated hospitals. Students are encouraged to make application at the completion of their freshman year.

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Pathology Comment

Items published here are provided by the Michigan Pathological Society

Cytology of Pregnancy

Characteristic patterns in vaginal cytology have been observed in pregnancy. Recent studies have extensively evaluated cytologic deviation from the normal pattern in relation to clinical pregnancy abnormalities including abortion and postmaturity, as well as anticipating the onset of labor at term.

The normal menstrual cyclic changes reflect the preovulatory estrogen secretion and the post ovulatory progesterone influence by a shift from exfoliation of estrogenic type surface cells with pyknotic nuclei (maturation index: 0/10/90) to progesteronal effect with a preponderance of intermediate cells (maturation index 0/70/30.) With the onset of pregnancy there usually is a persistence of an estrogenic type maturation index for a number of weeks. However, increasing numbers of curled basophilic intermediate cells (navicular cells) appear to establish the characteristic pregnancy picture by the third month of gestation and usually somewhat earlier. *The actual diagnosis of pregnancy can be frequently made on the basis of these changes, but is less accurate and is apt to occur later than other laboratory tests and is of little practical value.* If the pregnancy continues normally there is change to a more acidophilic superficial cell type preceding labor. Immediately after delivery the pattern shifts to one similar to atrophy with parabasal cells in greatest number.

Deviations from the normal cytologic pattern have been utilized in the anticipation and hormonal treatment of spontaneous abortion. Failure to establish the midzone maturation with characteristic curled navicular cells by the third month has been considered as an ominous sign of hormonal imbalance and danger to the fetus. During pregnancy oral or parenteral estrogens behave more like progesterones in their effect on vaginal epithelium. In the presence of a persisting estrogenic type pattern (0/40/60) early in pregnancy, if the fetus and placenta are viable, administration of estrogens will shift (0/100/0). If estrogens cause an increase in the estrogenic pattern (0/20/80) there is a strong indication of fetal death. Abnormalities in the cytologic pattern have been used as indicators for the need of supplemental hormonal therapy during pregnancy. Due to variation in the pattern which may not be fully established in very early pregnancy, serial smears may be necessary to establish a trend.

Cytologic changes may begin approximately 10 days preceding labor. These proceed in a recognizable manner and labor can frequently be anticipated within several days. Serial examinations are again often necessary for accurate evaluation. In cases of prolonged pregnancy with a viable infant the normal midzone pregnancy pattern continues and labor can be anticipated in the usual manner. There is no characteristic cytologic change to identify true postmaturity. Fetal anoxia or death results in an early appearance of the post partum basal cells. This has been used clinically to evaluate the condition of the fetus and to suggest the necessity for prompt pregnancy termination if signs of fetal danger are found. It should be emphasized that certain aspects of these cytologic changes are controversial and in no way is intended to replace clinical evaluation of the individual patient.

The following precautions are imperative for adequate evaluation. Smears must be taken through an unlubricated speculum from the mid-lateral vaginal wall. Contamination with material from the cervix or vulva renders a confusing picture. Frequently, the process with local antibiotics may be necessary for adequate hormonal evaluation.

The smears must immediately be placed in fixative and are handled as any other Pap smear.

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Von Hamm: Acta Cytologica, 5:320, 1961.
Zidovsky: Acta Cytologica, 6:393, 1961.



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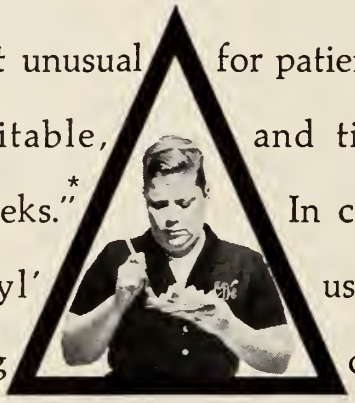
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Matlin, E.: The Obvious in Obesity, Clin. Med. 8:1071 (June) 1961.

FORMULA: Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine® (brand of dextro amphetamine sulfate) and 1½ gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 1 contains 10 mg. of 'Dexedrine' (brand of dextro amphetamine sulfate) and 1 gr. of amobarbital [Warning, may be habit forming]. The active ingredients of the 'Spansule' capsule are so prepared that a therapeutic dose is released promptly and the remaining medication, released gradually and without interruption, sustains the effect for 10 to 12 hours.

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SUPPLIED: Bottles of 50 capsules.

Smith Kline & French Laboratories SK&F *Prescribing information October 1962*

To Tell Public About Respiratory Ills

By A. W. Strom, M.D., Hillsdale, *Chairman*
Committee on Respiratory Disease,
Michigan Tuberculosis and Respiratory Disease Association



In the Spring of 1963, the National Tuberculosis Association and the Michigan Tuberculosis and Respiratory Disease Association will campaign to acquaint the public with the danger signals of chronic cough and shortness-of-breath.

Plans are under way to furnish to physicians, speakers at hospital and county medical society meetings to discuss in a more definitive way, the diagnosis and treatment of these diseases. Also, the MTRDA and its local affiliates will distribute to Michigan physicians, a guide, "Differential Diagnosis of Non-Tuberculous Respiratory Disease" prepared under the supervision of the American Thoracic Society, and a specially-prepared treatise, "Recommended Therapy for Selected Respiratory Diseases."

The MTRDA also plans to complete shortly a survey of pulmonary function testing facilities throughout the state and to develop an index of such facilities for guidance of physicians.

To further implement the program, the MTRDA will alert the general public through April and May to the import of the symptoms of chronic cough and shortness-of-breath by utilizing press, radio and television facilities and will make available to physicians, for distribution to the general public, pamphlets related to these problems. Stress will be placed on detection of emphysema, now believed to be affecting ten million persons in the United States, chronic bronchitis and asthma.

The co-operation of every member of the Michigan State Medical Society will be greatly appreciated in this campaign designed to improve the health of all the residents of the State of Michigan.



Miss Cecile Rutan of Hanover, right, and Miss Alice Budney of Milwaukee, admire the "Emmy" award which Miss Rutan received from Michigan Blue Shield as the Outstanding Medical Assistant of 1962 in Michigan. Miss Rutan won the award for her work as 1961-62 president of the Michigan State Medical Assistants Society. Miss Budney is President of the American Association of Medical Assistants. Sidney Adler, M.D., president of Blue Shield, made the presentation.

Governor Romney Lauds Professional People

In his proclamation of February 3-9 as "Professional Week," Governor Romney praised the professional men and women. In part he said:

"Michigan is proud of its professional people and their standards of excellence in research and practice. In serving well the public interest, our Michigan members of the professions have merited national acclaim. Their excellence and number are an inducement to business, industry and labor to locate in Michigan."

The resolution focused attention on the work of the Michigan Association of the Professions, stating in part:

"Leadership in encouraging the highest principles of professionalism has been demonstrated in the formation of the Michigan Association of the Professions. This organization has as its goal the best utilization of the knowledge and skill for the benefit of all our people and to encourage all the professions to work toward that goal."

In the ten years before 1948, the number of winners of the Nobel Prize in medicine between the United States and England was in balance—four for the United States and three for England. Since England adopted socialized medicine in 1948, American research has produced 19 Nobel Prize winners in medicine, while England has had but four.

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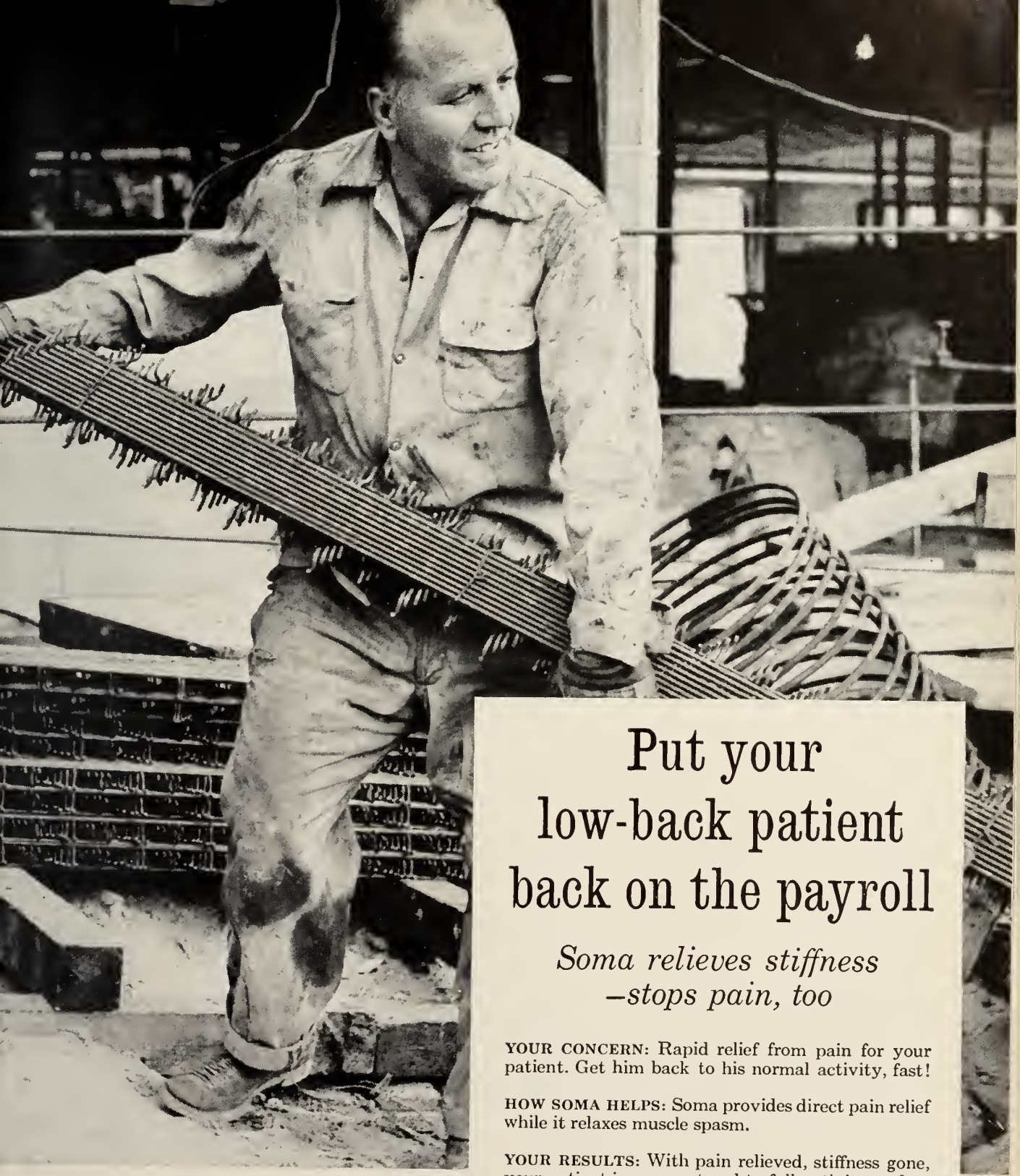
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> Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

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MICHIGAN DEPARTMENT OF HEALTH
ALBERT E. HEUSTIS M.D., State Health Commissioner

Policy on Poliomyelitis Vaccine

Recommendation was made by the Michigan Department of Health in August, 1962, that the use of Sabin Oral Vaccine be stopped in Michigan except under conditions of epidemic occurrence of poliomyelitis. This was because of the reporting of two cases of paralytic disease within 30 days of receipt of Type III Oral Sabin Vaccine in separate community programs. The total number of people of all ages who had received Type III in Michigan at that time was slightly over 100,000. Patients involved were 23 and 30 years of age. This was followed by similar action in Washington State and Canada.

Subsequently, the U. S. Public Health Service, because of similar cases being reported from several states in the nation and Canada, recommended that Type III Oral Polio Vaccine not be used for adults except under epidemic conditions or foreign travel to endemic areas. It recommended the utilization of Type III for only preschool and school age children. As a result of this, the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics stated on October 8, 1962, as follows:

"The consensus of the Committee on Control of Infectious Diseases is that there now exists a reasonable doubt in the minds of experts about the safety of the Type III vaccine, and therefore, the prudent approach is to withhold judgment and postpone its use in children as well as adults pending further study and appraisal by the Surgeon General's Advisory Committee.

"If Type III vaccine virus is ultimately shown to be responsible for the reported cases in adults, then one must be concerned about the risk to children and to young parents who might become infected from their children if community wide Type III vaccination programs are instituted in preschool and school age children. For these reasons, the Committee on Control of Infectious Diseases is unanimous in recommending that use of Type III live oral polio vaccine be delayed until the situation is further clarified.

"There is no emergency about use of the live, as opposed to the killed vaccine, except in epidemic areas. Paralytic poliomyelitis is at its lowest incidence in recorded history in the United States and there is ample time to complete the community-wide projects before the next poliomyelitis season if started as late as January or February. In the meantime, since Salk vaccine contains the only acceptable Type III antigen, continuation of its use is recommended."

Study of the Recommendations of the Surgeon General, U. S. Public Health Service made on December 19, 1962, following a meeting of his advisory committee on oral poliomyelitis vaccine has been completed. The advisory committee determined that the following cases of paralytic polio were "compatible" with the possibility of having been induced by Sabin Oral Vaccine:

Type I	7 cases	4 over 30 years
Type II	0 cases	
Type III	11 cases	8 over 30 years
Contact Cases (Type not stated)	3 cases	Ages not stated
Total Related Cases	21 cases	

It is of interest that cases of Type I have now been officially included in those considered "compatible."

The recommendations of the advisory committee on oral poliomyelitis vaccine which the Surgeon General offered in a release on December 19, 1962, are as follows:

"It is therefore recommended: (1) that community plans for immunization be encouraged, using all three types, and (2) that immunization be emphasized for children in whom the danger of naturally occurring poliomyelitis is greatest and who serve as the natural source of poliomyelitis infection in the community. Because the need for immunization diminishes with advancing age and because potential risks of vaccine are believed by some to exist in adults, especially above the age of 30, vaccination should be used for adults only with the full recognition of its very small risk. Vaccination is especially recommended for those adults who are at higher risk of naturally occurring disease; for example, parents of young children, pregnant women, persons in epidemic situations, and those planning foreign travel. Of greatest importance is the planning of continuing vaccination programs to provide for the adequate immunization of the incoming generation."

The Advisory Committee's report and the Surgeon General's recommendations confirm there is risk to the use of oral vaccine, especially in adults. Our ex-

(Continued on Page 318)



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Literature on request

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POLICY ON POLIOMYELITIS VACCINE

(Continued from Page 316)

perience in Michigan indicates this risk is at least ten times greater (1 to 100,000) as compared with the consolidated experience nationwide. If oral vaccine was responsible and projecting this experience to our total population, (estimated at 7,900,000) this could have meant 75 cases of paralytic disease in 1962, had everyone in the state received oral vaccine. It is on Michigan's experience that our judgment of safety to our population must rest. The Surgeon General's recommendations have not minimized the risk. Infants are not included in the present recommendation of the Surgeon General nor was there any definite recommendation that Sabin Oral Vaccine be used in other than a mass community program for children and young adults. Many authorities believe such programs would entail risks to unvaccinated adult contacts, especially family situations.

With this background and on the basis of present information, the Michigan Department of Health recommends:

1. That in the absence of an epidemic, Salk poliomyelitis vaccine be used in all community poliomyelitis protective programs as well as for individual poliomyelitis immunization in physicians' offices.

2. That communities desiring to enter into elective mass immunization programs with Sabin Oral Vaccine as recommended by the Surgeon General should only do so under the following conditions:

(a) The approval of the local medical society or societies and their willingness to accept responsibility for risks now determined to exist in relation to Sabin Oral Vaccine by the Surgeon General's Advisory Committee on oral vaccine. The individual physician in charge must accept the direct responsibility.

(b) Careful adherence to the manufacturers' recommendations in all aspects including that of season.

(c) Adequate records so that information on the type received by each individual, name of manufacturer, lot number of vaccine, and signature of physician under whose responsibility vaccine is given is readily available.

(d) Since infants are not included in the Surgeon General's December 19, 1962 recommendations to receive oral vaccine, it is of the utmost importance they be adequately protected with Salk vaccine. Provision and assurance that all infants (under one year) are being given basic protection with Salk vaccine either alone or in combination with other antigens must be obtained. Simultaneous provision for basic protection against whooping cough, diphtheria, tetanus, and smallpox should also be stressed.



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Sees MSMS Membership Necessary for County Members

Dear Doctor:

I am informed that the question has again been raised by a county society as to whether or not a doctor may be a member of his county society without being a member of and paying dues to the state society.

Some two years ago, I reluctantly expressed the opinion that a doctor could be a member of his County Society without being obliged to be a member of the State Society. I based this opinion primarily on that provision of the by-laws which recognizes that a county society shall be the sole judge of the qualifications of applicants for membership therein. At the same time, I expressed the opinion that to elect to county society membership without requiring membership in the state society would, in many respects, be contrary to the general spirit and intent of the constitution and by-laws of the state society and that a county society should be very reluctant to do so even though it had the power.

Further consideration and study of the matter has convinced me that my former opinion was erroneous and that, insofar as voting membership in a county society is concerned, the member must also be a member of the state society.

Section 1 of Chapter II of the State Society by-laws provides that: "active members of this Society shall comprise all the active members of the several component County Societies." When this provision of the by-laws is considered in connection with the basic organizational concept of the Society, namely, that county societies are component of the state society and owe their very existence to the state society through charter from the state society, it seems to me that no other conclusion can be reached than that one cannot be a member of the component without being a member of the whole.

Numerous other provisions of the constitution and by-laws would become inconsistent were any other conclusion to be reached. For an example of the utterly anamalous situation that might result from permitting active membership in a county society without membership in the state society, let us assume that all of the active members of a county society elected to refrain from membership in the state society. The result would be a totally autonomous county society chartered by the state but without members therein. Presumably such a society could elect delegates to the House of Delegates and participate in government of the state society without obligation to or membership therein.

It will be noted that the provisions of the by-laws governing classes of membership other than active membership recognize that one may be elected to such class of membership in a county society without necessarily being elected to the same type of membership in the state society. It is my opinion, however, that election to



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active membership in a county society constitutes an election to active membership in the state society.

Sincerely yours,
LESTER P. DODD,
Legal Counsel

Refers to Policy Re Allied Professions

Dear Doctor:

I have your inquiry of January 20, 1963, with respect to the liability of the admitting physician for the work of a podiatrist or member of any of the allied health professions.

As you know, under the rules of the Joint Commission on Accreditation and the Statement of Policy re Allied Health Professions and Services in Hospitals* adopted by the State Society last year, every patient admitted for services to be performed by a member of one of the allied health professions must not only be admitted by a staff physician but the staff physician must take the history, do a physical examination and be responsible for the patient's medical care throughout his stay. The Statement of Policy further provides that the treatment must be under the direction and supervision of a physician or surgeon member of the medical staff of the hospital who is appropriately qualified in the particular field.

Under these rules and Statement of Policy, it is unquestionably true that the admitting physician must assume general responsibility for the proper care of the patient and cannot treat his admission of the patient as merely a perfunctory act performed for the purpose of complying with a hospital rule or regulation.

Since I have recently written an opinion on this subject in which I have discussed the problems in some detail, I enclose herewith for your information a copy of that opinion dated June 22, 1962.

If this does not sufficiently clarify the matter, please feel free to get in touch with me further.

LESTER P. DODD,
Legal Counsel

*EDITOR'S NOTE: Copies are available from MSMS.

The Maricopa County Medical Society in Arizona tries to make residents safety-conscious with a booklet containing answers to questions about what to do when emergencies arise. A continued series of medical features on safety and emergency care was promoted in the local papers. A campaign to advocate the use of safety belts was carried on in cooperation with the police.

Cites Medical Achievements; Sees Relation to Freedom

(Excerpts from Address by George M. Fister, M.D., President, AMA, to AMA House of Delegates, Los Angeles)

Today, medicine stands as a proud symbol of the finest achievements of our competitive enterprise system.

Our profession has helped to bring this nation the world's foremost record in medical care and progress. This has been accomplished by the efforts of the devoted members of the health team who have always doggedly resisted pressures to bring this dynamic system under the deadening anesthesia that federal control would bring to this program.

The progress of medicine in this nation is one of the most dramatic stories of the century.

Let's look at a few pages of the record:

—4½ million Americans are alive today who would be dead if the mortality rate of 25 years ago still prevailed. And these 4½ million people earned almost 10½ billion dollars in 1960.

—For the first time in our history, life expectancy for Americans has exceeded the Biblical three score and ten years, and it now stands at 70.2 years.

—80 per cent of the drugs commonly prescribed today were unknown just ten years ago.

—The United States has made more important drug discoveries in the last two decades than all the rest of the world combined, or seven times as many as the next leading country.

—Just last year the prescription drug industry set a new record of 245 million dollars in research, an investment triple that of the average industry.

—There now is a record number of hospital beds in this country—one million, 670 thousand, an increase of more than a quarter million beds since 1948.

—The average stay in a hospital is at its lowest in history.

—During the year, infant mortality rates declined to the lowest in United States history, 25.3 deaths per 1,000 births.

—A record number of 7,168 new physicians graduated from U. S. medical schools this year, and a record number of 31,078 students are enrolled in medical schools.

—In 13 years this nation built 763 new hospitals, increasing the total number of hospitals to almost 7,000.

—A record number of Americans, 136 million, is covered by voluntary health insurance and prepayment plans.

These accomplishments did not "just happen." They came about because researchers, medical scientists, and physicians have had an opportunity to work in an atmosphere of freedom.

Achievement and freedom are not unrelated.

Free men have had the opportunity to develop this medical care



system under a government and a constitution that encourage enterprise and industry. Men have been free to think, to work, to match their talents against the world.

Change AMA-ERF Regulations

A change in the AMA-ERF Loan Program has been made which will benefit borrowers who wish to make lump sum repayments of any size, in addition to their regular monthly repayments, during their pay-out period. Borrowers may make additional payments of any size along with their regular monthly payment to reduce the principal as quickly as possible. The entire amount of such prepayment services to reduce the principal immediately and, therefore, reduces interest costs, since interest is paid only on the outstanding balance.

The AMA-ERF Loan Guarantee Program is continuing without curtailment and applications will be accepted so long as the Guarantee Fund permits extension of new credit. The Fund is now 80% committed by the more than 5,000 loans made to date.

Farm Bureau Compliments Hardwick on C-C Article

An effective article about the King-Anderson proposal was written for the January issue of *Michigan Challenge* by Dr. Clyde Hardwick, MSMS economic consultant. (The *Challenge* is the official publication of the Michigan State Chamber of Commerce.)

Professor Hardwick received several congratulatory letters including this one from Dan E. Reed, Associate Legislative Counsel, Michigan Farm Bureau:

"I have read with interest your economist-eye-view of the King-Anderson Medicare bill in the January issue of *Michigan Challenge*. I think you have simplified the whole matter in the answer which you have given to the question—'What is the Central Issue?'

"A lot of folks are attempting, intentionally or otherwise, to transpose the issue into one which could be simply stated—'Are you for or against older people?' Your article should be really helpful.

"Would you object to our reprinting part, or all, of it in our Farm Bureau publication?"

Study Welfare Cases in California

What happens to the health of a welfare recipient once his welfare payments have been exhausted? California officials are trying to find out. With the help of the U. S. Public Health Service, they are conducting a two-year health survey among the state's longtime unemployed.

Begin New Survey of Michigan's Economy

Michigan's population in the year 2000, its job needs and industrial patterns are the concern of the Michigan Economic Development Department under a federal-state Resource Development Program.

The project, estimated to cost $1,125,000, is being financed by a $750,000 federal grant under the Housing and Home Finance Agency. The remainder of the expense is represented by state services and staff.

The program is designed to analyze existing and gathered data on Michigan's economy with the aim of providing more jobs and promoting the general economic well-being of Michigan.

Health Insurance Coverage Establishes New Records

The health insurance business in 1962 reached new highs both in the number of persons covered and in the amount of benefits paid out. The Health Insurance Institute reports that 140 million persons—or 75 per cent of the civilian population of the United States—were protected by some form of health insurance, an increase of 3.5 million over the record figure of 136,522,000 reached in 1961. The Institute also estimated that health insurance benefit payments during 1962 totaled $7.1 billion, an increase of 11.5 per cent over the record $6,397,000,000 paid out in 1961.

The American people received the coverage and the benefits from some 1,800 voluntary insuring organizations, including 839 insurance companies, 77 Blue Cross plans, 69 Blue Shield plans, and nearly 800 other health plans, according to the Institute.

Statistics on Diabetics Cited

It is estimated that one American in every 60 is a diabetic, and that there are approximately three million diabetics in the nation today. Of this number about 1,600,000 know that they are diabetic, and roughly 1,400,000 are unaware of their condition.

Approximately 5,125,000 other persons living today are potential diabetics. About 75,000 persons are known to become diabetic each year.

Diabetes is hereditary. Of the total population of the United States, one out of every four persons—or 45 million people—are believed to be diabetic "carriers."

More than 85 per cent of all diabetics are over 45 years old. Three out of five in this age group are women, and six out of seven were overweight when their condition was discovered.

Brief and to the Point

TELLS ABOUT PERU—J. D. Langston, M.D., Detroit, recently told the Wayne County Pathologists about his experiences with the S.S. HOPE in Peru. The meeting was held in the auditorium of David Whitney House. Doctor Langstron is one of four Michigan pathologists who have served with Project Hope in Indonesia, Vietnam, and Peru.

UROLOGICAL PRIZES—Speakers at the Detroit Branch of the American Urological Association meeting recently included Arthur Johnson, M.D., Detroit, on "Observations of Bladder Regeneration." The final meeting will be on May 22 at the Wayne County Medical Society in Detroit when cash prizes will be given for the best 3 resident papers presented. To be eligible for a prize, a copy of the paper must be in the hands of the Secretary, Murray S. Mahlin, M.D., by May 1.

SPEAK IN VIRGINIA—W. Kaye Locklin, M.D., Kalamazoo, and Charles D. Beamer, M.D., Dearborn, will speak at the Medical College of Virginia in April during the course in "Expanded Surgery of the Nasal Septum and Closely-Related Structures."

HONORED BY JCC—The first community service award ever given by the Petoskey Junior Chamber of Commerce was presented recently to Dean C. Burns, M.D., founder of the Burns Clinic and the Little Traverse Hospital. Dr. Burns also was cited for his efforts to establish the North Central Michigan College at Petoskey.

SPEAKS ON CANCER—Henry J. Vanden Berg, Jr., M.D., Detroit, chairman of the MSMS Cancer Control Committee, gave the keynote speech February 19 at a conference called by the Michigan Tuberculosis and Respiratory Disease Association in Lansing to discuss "Smoking and the Teen-Ager." Representatives of many youth, health and educational organizations participated in the session to explore ways to increase the effectiveness of educational programs to alert teen-agers to the dangers of cigarette smoking.

NATIONAL PRESIDENT—Albert E. Heustis, M.D., state health commissioner, is the new president of the Association of State and Territorial Hospital and Medical Facilities Survey and Construction Authorities. This national organization guides the U. S. Public Health Service in the federal Hill-Burton Hospital construction program.

JOINS WSU STAFF—Joseph A. Witter, M.D., Highland Park, has joined the faculty of Wayne State University College of Medi-



cine as assistant professor of surgery. A graduate of the University of Michigan Medical School, Doctor Witter had served as chief of the department of surgery at the Highland Park General Hospital.

* * *

EXPANDS FIRM—Lester P. Dodd, D.J., legal counsel for MSMS, announces that his firm of Crawford, Sweeny, Dodd and Kerr will continue its practice under the firm name of Sweeny, Dodd, Kerr, Wattles and Russell.

* * *

ON SAN JUAN PROGRAM—Five Michigan surgeons participated in the combined meeting of the Cardiovascular Surgeons Club with the Puerto Rican section of the American College of Surgeons in San Juan, February 20 to 23. These surgeons and their papers are as follows: Robert Berry, M.D., Ann Arbor—"The Water and Electrolyte Problem Attendant to Portal Hypertension and the Response to Portal Decompression"; Alexander Blain, II, M.D., Detroit—"Raynaud's Disease and Raynaud's Syndrome"; James B. Blodgett, M.D., Detroit—"Power Wiring of Unresectable Aortic Aneurysm"; Conrad R. Lam, M.D., Detroit—"Excision of Ventricular Aneurysm"; and Sherwood B. Winslow, M.D., Battle Creek—"Use of the Sauerland-Kutz Vein Stripper in Cure of Varicose Veins and Ulcerations".

* * *

EAR BANKS—The Temporal Bone Banks Program for Ear Research is sponsored by the American Academy of Ophthalmology and Otolaryngology and The Deafness Research Foundation of New York City. The Temporal Bone Banks Center is indebted to The Deafness Research Foundation for launching and providing the financial support for it during the initial year and to the United States Public Health Service for additional grants.

The Michigan Banks are at Henry Ford Hospital and the University of Michigan Medical Center.

* * *

STAFF CHANGES—The Haven Sanitarium at Rochester reports that the office of clinical director has been changed to that of medical director and Ralph S. Green, M.D., now holds that post, and Lawrence Koltonow, M.D., is assistant medical director. Morris Frumin, M.D., and Sheldon N. Siegel, M.D., have been appointed as Active Staff Psychiatrists.

* * *

GRANTS TO MSU—The Michigan State University Board of Trustees recently accepted a $2,000,000 grant from the National Institutes of Health to support construction of biochemistry and veterinary medicine buildings. The biochemistry building will cost $5.2 million, and the veterinary medicine building will cost $3.5 million.

* * *

NEW MEDICAL CENTER—Plans for a $25-million medical office building complex in the new Detroit Medical Center were announced recently by M. E. Arden and H. F. Campbell, owners and developers for the project. The de-



velopers plan the 16-building complex for 15.4 acres of land bounded by Woodward, Mack, John R and Alexandrine. Included in the center will be three 11-story professional medical office buildings, a seven-story and three one-story general office buildings, five one-story structures for stores and shops and four multi-level parking facilities for 1750 cars. The project is one of the largest of this type to be erected in the country.

* * *

GUEST SPEAKER—Jean B. Rosenbaum, M.D., Detroit, presented a paper co-authored by Mayer Subrin, M.D., Detroit, "The Psychology of Group, and Some Misuses and Abuses of our Private Language" at a Puerto Rico conference in January.

* * *

CANCER COMMITTEE ELECTS LEADERS—



B. E. Luck, D.D.S., Lansing, has been re-elected chairman of the Michigan Cancer Coordinating Committee. First vice-chairman, Henry J. VandenBerg, Jr., M.D., Detroit, and second-vice-chairman, J. W. Cowan, M.D., Lansing. Wm. J. Burns was re-elected as secretary-treasurer.

BORDEN GRANT—The Borden Foundation of New York City has given the University of Michigan Medical School $2,500 to recognize outstanding student research efforts. The senior medical student whose research work is adjudged the best in class will receive $500.

* * *

COMING COURSES—The following intramural courses are offered by the University of Michigan Medical Center:

March 25-30 Electrocardiograph Diagnosis
April 1-3—Radiology, Diagnostic
April 8-10—Pulmonary Diseases
April 15-19—Endocrinology and Metabolism
April 15-May 3—Anatomy (Obstetrics & Gynecology)
April 15-May 31—Anatomy (Surgery)
April 18-20—Otorhinolaryngology Conference
April 22-24—Ophthalmology Conference
April 22-26—Recent Advances in Therapeutics
May 7-18—Pathology (Obstetrics & Gynecology)

* * *

STUDY PSYCHIATRY—Sixty Michigan State Troopers participated recently in a five-day "institute" at the University of Michigan Medical Center to study modern social and psychiatric concepts affecting police work. The institute was initiated by Police Commissioner Joseph A. Childs and Raymond W. Waggoner, M.D., Ann Arbor.

(Continued from Page 328)



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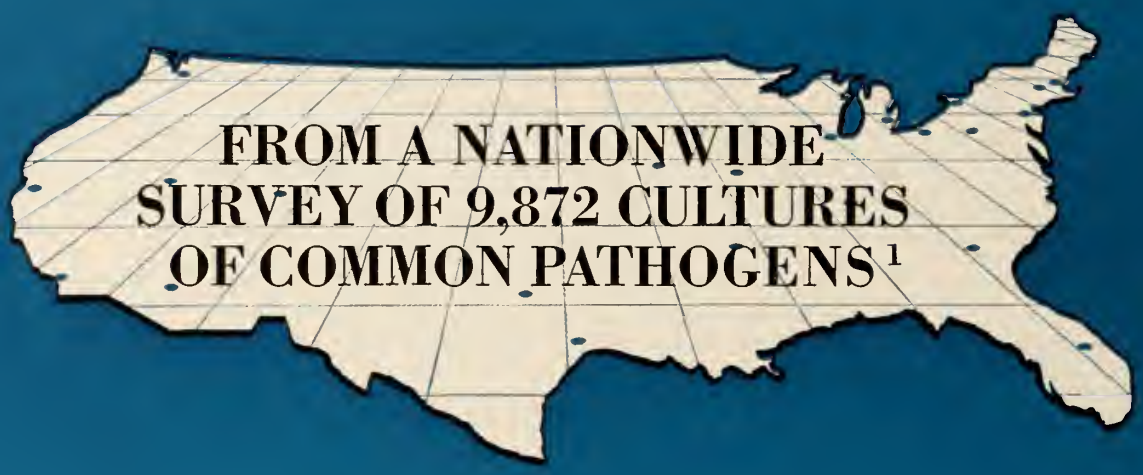
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THIAMINE MONONITRATE (B_1)	3 mg.	FERROUS SULFATE EXSICCATED	50 mg.
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PYRIDOXINE HCl (B_6)	1 mg.	COPPER	1 mg.
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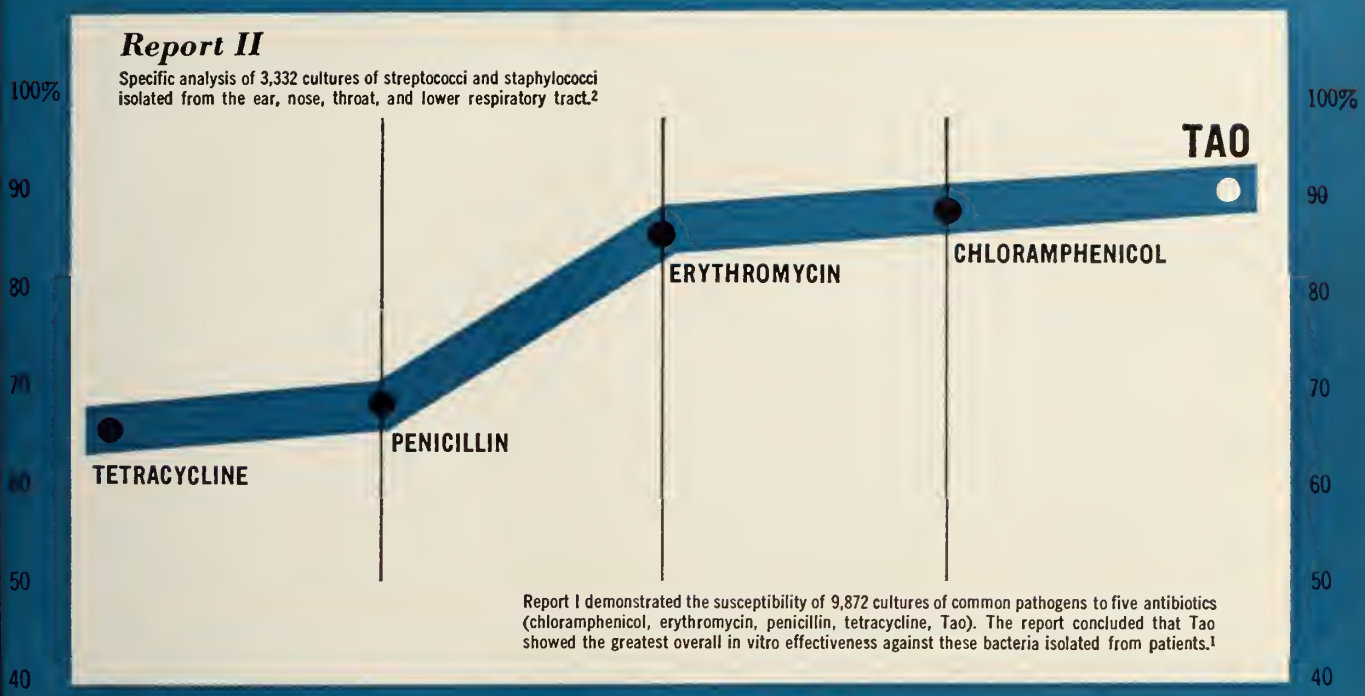
FROM A NATIONWIDE SURVEY OF 9,872 CULTURES OF COMMON PATHOGENS[1]

Conclusions of Nationwide Survey: *Report I*

1. **Even after five years of general use,** Tao, of the antibiotics tested, demonstrated greatest activity against respiratory streptococci and staphylococci (3,332 cultures).

2. **Overall results showed a higher percentage of susceptibility** among these common pathogens to Tao than to the other antibiotics. Susceptibility to Tao was greatest, not only in respiratory streptococci and staphylococci, but also in these organisms isolated from skin and soft tissue (3,423 cultures), genitourinary and gastrointestinal tracts and other sources (2,458 cultures). Susceptibility was equal to all antibiotics tested in pneumococci from unspecified sources (463 cultures), and less to Tao in H. influenzae from unspecified sources (196 cultures).

3. **Tao has been used for five years without development of predictable cross resistance.** In 1958 and 1961, approximately 73% and 70%, respectively, of erythromycin-resistant problem staphylococci showed susceptibility to Tao.[3,4] The present study confirms the continuing high degree of Tao activity even against these pathogens. Of 1,592 cultures of erythromycin-resistant staphylococci, 68% were susceptible to Tao, while in the reverse situation, only 33% of 768 Tao-resistant staphylococci were susceptible to erythromycin.



Report II

Results of Bacterial Susceptibility in 3,332 Respiratory Pathogens

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3. English, A. R., and Fink, F. C.: Antibiot. & Chemother. 8:420 (Aug.) 1958.
4. English, A. R., and Fink, F. C.: Antibiot. and Chemother. 11:648 (Oct.) 1961.

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(Continued from Page 325)

HEADS VA HOSPITAL—Allen W. Byrnes, M.D., formerly director of the Veterans Administration Hospital at Knoxville, Iowa, is the new director of the VA hospital at Battle Creek. He succeeds Ernest J. Jones, M.D., who has retired. Mr. Byrnes received his medical degree from the State University of Iowa in 1934. After several years in private practice, he joined the Veterans Administration in 1940 and has served at VA hospitals at Battle Creek, Dayton, Ohio, Downey and Dansville, Illinois and St. Cloud, Minnesota, before going to Knoxville.

* * *

ON S.S. HOPE—Two Michigan physicians will be among the 26 physicians and two dentists who will make up the seventh and final team of "rotators" serving aboard the hospital ship S.S. HOPE during its current visit to Peru. The doctors are: Harvey H. Glass, M.D., Detroit, and Donald R. Simmons, M.D., Huntington Woods.

* * *

COMMUNITY EVENT—About 600 townspeople gathered at the Elsie High School recently to help E. M. Slagh, M.D., celebrate his 25th year of practice in the area. The event also observed the 25th wedding anniversary of Doctor Slagh and his wife, Carol. He was graduated from the St. Louis University School of Medicine and interned at Bay City Mercy Hospital before locating at Elsie.

* * *

WSU GRANTS—Several grants were accepted at the last meeting of the Wayne State University Board of Governors from the U. S. Public Health Service for projects, including: E. E. Muirhead, M.D., Bloomfield Hills, and Earnest Booth, M.D., Birmingham, for continuation of research in renal explants and extracts in renoprival hypertension; and Frederick J. Margolis, M.D., Kalamazoo, for a study of the effect of fluorine on teeth when given from infancy.

* * *

CITED—George M. Brown, M.D., Bay City, recently received a certificate of appreciation from the Bay County Selective Service Board for 20 years of service as the medical advisor.

* * *

HONORED—The Hospital Board of Managers of the Foote Hospital in Jackson recently honored Ross V. Taylor, M.D., Jackson, at a dinner for his six years of service on the Board. A resolution cited his cooperation and assistance.

* * *

WAYNE ALUMNI REUNION—The 95th Alumni Reunion and Clinical Program of Wayne State University's College of Medicine will be held Wednesday, May 8, at the Sheraton-Cadillac Hotel.

The scientific program, featuring eight papers, begins at 9:30 a.m. A reception at 6 p.m. will precede the reunion dinner dance.

President of the alumni group is Herbert W. Devine, M.D. President-Elect is Jacob F. Wenzel, M.D. Details will be announced later.

(Continued on Page 330)



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(Continued from Page 328)

ENDS SERVICE—Sumner H. Whittier ended his service as executive director of Michigan Medical Service on February 28.

Sidney Adler, M.D., Chairman of the Board of Directors of Michigan Medical Service, said that Mr. Whittier's decision not to seek renewal of his contract was "accepted with regret."

A former lieutenant governor of Massachusetts, Mr. Whittier formerly served as head of the Veterans Administration under President Eisenhower.

MEETINGS USA

American Academy of Neurology, Leamington Hotel, Minneapolis, April 22-27; Charles A. Kane, M.D., 80 E. Concord St., Boston.

American Association of Pathologists and Bacteriologists, Netherlands Hilton Hotel, Cincinnati, April 26-28; John R. Carter, M.D., University of Kansas Medical Center, Kansas City 3.

American Association for Thoracic Surgery, Shamrock Hilton Hotel, Houston, April 8-10; Henry T. Bahnson, M.D., Johns Hopkins Hospital, Baltimore 5.

American College of Obstetricians and Gynecologists, Statler Hilton Hotel, New York City, April 21-24; Craig W. Muckle, 1806 Garrett Rd., Landsdown, Pa.

American College of Physicians, Denver-Hilton Hotel, Denver, April 1-5; Edward C. Rosenow, Jr., M.D., 4200 Pine St., Philadelphia 4.

American College of Surgeons (sectional meeting), Royal York Hotel, Toronto, April 25-27; Samuel P. Harbison, M.D., 40 E. Erie St., Chicago 11.

American Otological Society, Hollywood Beach Hotel, Hollywood, Florida, April 26-27; James A. Moore, M.D., 525 E. 68th St., New York 21.

American Pediatric Society, Seaside Hotel, Atlantic City, N. J., May 3-4; Conrad M. Riley, M.D., 2800 E. Cedar Ave., Denver 9.

American Proctologic Society, St. Francis Hotel, San Francisco, May 20-23; Norman D. Nigro, M.D., 7815 E. Jefferson, Detroit 14.

American Urological Association, Sheraton-Jefferson Hotel, St. Louis, May 13-16; William P. Didusch, 1120 N. Charles St., Baltimore 1.

International College of Surgeons (North American Federation Congress), Ambassador Hotel, Los Angeles, April 22-26. Horace E. Turner, M.D., Secretary-General, 1516 Lake Shore Drive, Chicago 10.

Student American Medical Association, Sherman House, Chicago, May 1-5; Russell F. Staudacher, 333 N. Michigan, Chicago 1.

Trudeau School of Tuberculosis and Other Pulmonary Diseases, Forty-eighth Session, Saranac Lake, N. Y., June 3-21; Secretary, Trudeau School of Tuberculosis and Other Pulmonary Disease, Box 670, Saranac Lake, N. Y.

Wisconsin State Medical Society, Milwaukee, May 7-9; D. H. Crownhard, Box 1109, Madison 1.

IN MEMORIAM

A. J. ANDERSON, M.D., 67, Muskegon physician for 25 years, died January 17, 1963.

A graduate of the University of Michigan, Doctor Anderson practiced several years in New Buffalo before establishing his general practice in Muskegon. He served his internship at Highland Park General Hospital and his residency at St. Luke's Hospital in Chicago. Following his residency he was on the staff of the Logansport (Ind.) State Hospital.

ALEXIUS BANACH, M.D., 62, Newberry, died January 13, 1963.

Doctor Banach, who was on the staff of the Newberry State Hospital, was a native of Poland. He was a graduate of the University of Poland at Karkow. He was on the staff of the State Hospital in Sault Ste. Marie before moving to Newberry in 1950.

HERBERT G. BARAK, M.D., 55, Kalamazoo physician since 1946, died January 4, 1963.

A graduate of Wayne State University School of Medicine in 1939, Doctor Barak served in the Army Medical Corps for four years prior to beginning general practice in Kalamazoo.

He was a member of the American Academy of General Practice.

PAUL L. DeWAELE, M.D., 53, Bay City surgeon, died January 4, 1963.

A 1935 graduate of Georgetown University Medical School, Washington, D.C., Doctor DeWaele was in the Army Medical Corps from 1942 to 1944.

Memberships included the Michigan Society of Neurology and Psychiatry, New York Academy of Science, American Society of Abdominal Surgeons, American Geriatrics Society, and American Academy of General Practice. He was on the board of directors of Mercy Hospital in Bay City.

DONALD R. GRADY, M.D., 49, Flint, medical director of the Genesee County Welfare Department, died December 24, 1962.

A graduate of Northwestern University Medical School, Doctor Grady moved to Flint in 1946 to serve an internship at Hurley Hospital. Following this, he was chief resident physician at St. Joseph Hospital.

He served as medical examiner for Genesee County in the early 1950's. He was on the staffs of Winchester, Hurley, McLaren General, St. Joseph and Genesee Memorial Hospitals. Memberships included the Michigan Hospital Association and the American Public Welfare Association.

LEE A. LEWIS, M.D., 88, Manistee physician for 40 years, died December 26, 1962.

A graduate of Detroit College of Medicine, Doctor Lewis practiced for 10 years in Barryton before moving to Manis-

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tee. He was a Life Member of the Michigan State Mental Society. He was a former member of the Manistee Board of Education.

FREDERICK E. LUGER, M.D., 56, Saginaw general practitioner, died January 22, 1963.

A 1931 graduate of the Detroit College of Medicine and Surgery, he served his internship at Harper Hospital and his residency at St. Mary's Hospital in Saginaw. He began practice in Saginaw in 1933.

A past president of the Saginaw County Medical Society, he was a charter member and first president of the Saginaw Academy of General Practice. He was also a member of the American Academy of General Practice. He was a member of St. Mary's Hospital senior staff.

OSCAR P. ROSBOLT, M.D., 61, Livonia physician and surgeon, died January 16, 1963.

A graduate of Wayne State University College of Medicine, Doctor Rosbolt served his internship at Detroit's Providence Hospital.

Doctor Rosbolt was chairman of the Livonia Civil Service Commission. He was a member of the College of Abdominal Surgeons, member of the attending surgical staff at Mt. Carmel Hospital, first president of the Board at St. Mary Hospital and president of the Advisory Board of the new Madonna College.

I. V. YALE, M.D., 83, Sault Ste. Marie physician since 1906, died December 13, 1962.

A graduate of the Detroit Medical College, Doctor Yale practiced with his father at Deerfield for two years before going to Sault Ste. Marie. He was a life member of the Michigan State Medical Society.

Michigan Authors

Sidney Auerback, M.D., Rosser Mainwaring, M.D. and **Frank Schwarz, M.D.,** Dearborn, "Renal and Uretheral Damage Following Clinical Use of Renacidin", *Journal of the American Medical Association,* January 5, 1963.

Charles H. Frantz, M.D., Grand Rapids, "Increased Incidence of Malformed Infants in West Germany During 1959-1962", *Illinois Medical Journal,* January, 1963.

J. S. Meyer, M.D., Detroit, "Ischemic Cerebrovascular Disease (Stroke)", *Journal of the American Medical Association,* January 26, 1963.

Alfred A. Wick, M.D., Robert H. Joseph, M.D. and **Alfred Nerdrum,** Ann Arbor, "A Clinical Investigation of Contact Lenses", *Journal of the Indiana State Medical Association,* January, 1963.



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The Doctor's Library

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review as expedient.

IMMUNOASSAY OF HORMONES. Ciba Foundation Colloquia on Endocrinology. Volume 14. Editors for the Ciba Foundation: G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Margaret P. Cameron, M.A. With 85 Illustrations. Boston: Little, Brown and Company, 1962. Price, $10.75.

This is another in the Ciba sponsored series of symposia on Endocrinology, dealing with the "detection and assay of hormones by immunochemical means." It represents the work of 28 international authorities, both Immunologists and Endocrinologists. The work is highly technical and follows the usual format of this series, with questions and discussions following the presentation of each paper.

This book is well printed and illustrated and is a valuable research source on a timely and interesting subject.

Subjects covered include Growth Hormones, Insulin, Glucagon, Thyrotropin, Corticotropin, Gonadotropins, and Prolactin.

R.W.B

PULMONARY STRUCTURE AND FUNCTION. Ciba Foundation Symposium. Editors for the Ciba Foundation: A. V. S. De Reuck, M.Sc., D.I.C., A.R.C.S., and Maeve O'Connor, B.A. With 101 illustrations. Boston: Little, Brown and Company, 1962. Price, $11.50.

This book represents the proceedings of a Symposium on Pulmonary Anatomy and Function held in July, 1961. Twenty-nine international authorities participated in a fairly free and informal exchange of ideas on the subject. Papers are as originally presented, followed by a text of the discussion following each paper, with only a minimum amount of editing.

The book is well illustrated and well printed, and represents a useful research source for Medical Libraries, much of it dealing with basic pulmonary anatomy and physiology.

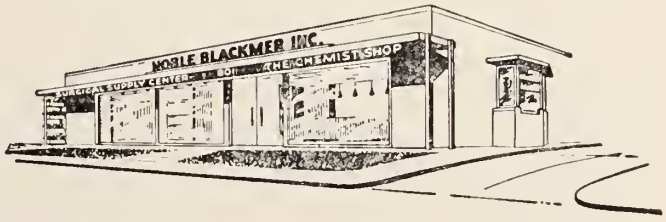
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DOCTOR AND PATIENT AND THE LAW. By C. Joseph Stetler, LL.B., LL.M., Member, Bar of District of Columbia and of Illinois; General Counsel and Director of Legal and Socio-Economic Division, American Medical Association, Chicago, Illinois, and Alan R. Moritz, A.M., Sc.D., M.D., Professor of Pathology and Director of the Institute of Pathology, Western Reserve University, Cleveland, Ohio. Fourth edition. Saint Louis: C. V. Mosby Company, 1962. Price $14.75.

This is the fourth edition which represents a substantially revised edition of the book by the same title, originally published by Doctor Louis J. Regan, now deceased. It deals

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The appendix contains a reprint of the principles of medical ethics of the American Medical Association, and a model constitution and by-laws for a County Medical Society.

A section of consent forms for various procedures, and releases, is presented in detail.

This book should find a place in all hospital libraries and in the libraries of many physicians who even occasionally testify in court.

R.W.B.

THE RELUCTANT SURGEON—A BIOGRAPHY OF JOHN HUNTER. By John Kobler, Dolphin Books. Garden City, New York: Doubleday & Company, Inc., 1962. Price $1.45.

A biography of John Hunter, medical genius and great inquirer of Johnson's England.

As the bicentenary of Hunter's birth approaches, several contributions to the Hunterian literature have been forthcoming. Mr. John Kobler has made an attempt to place Hunter in the proper perspective in which he might be remembered by the many generations of physicians who have, and are yet to follow him.

J.G.G.

BOOKS RECEIVED

THE MECHANISM OF ACTION OF WATER-SOLUBLE VITAMINS. Ciba Foundation Study Group No. 11. Editors for the Ciba Foundation: A. V S. deReuck, M.Sc., D.I.C., A.R.C.S., and Maeve O'Connor, B.A. 34 illustrations. Boston: Little, Brown & Company, 1962. Price, $2.50.

BIOLOGICAL EFFECTS OF FREEZING AND SUPERCOOLING. By Audrey U. Smith, D.Sc., M.B., B.S., National Institute for Medical Research, Mill Hill, London. Baltimore: Williams and Wilkins Company, 1961. Price, $11.00.

DRUGS OF CHOICE 1962-1963. Editor: Walter Modell, M.D., Director, Clinical Pharmacology, and Associate Professor of Pharmacology, Cornell University Medical College, New York, N. Y.; Attending Physician, Veterans Administration Hospital, Montrose, N. Y.; Associate Visiting Physician, Bellevue Hospital, New York, N. Y.; Member, Revision Committee, United States Pharmacopeia XVII; Editor, Clinical Pharmacology and Therapeutics. Saint Louis: C. V. Mosby Company, 1962. Price, $14.50.

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Editorial Comment

Kerr-Mills Expands With Little Front Office Help

(Grand Rapids Press)

Last year marked a notable expansion in the Kerr-Mills program for providing medical benefits for the most needy persons in the country, those over 65 and dependent on public assistance. But one would never know this from the latest report by the Department of Health, Education and Welfare, which finds it advisable to devote only one paragraph to Kerr-Mills in a 16-page report. That paragraph is concerned only with noting that 18 states now are under the Kerr-Mills plan and that average payments to individuals dropped in the fiscal year that ended last June 30.

But other sources have dug out some more revealing facts, one of which is that the total number of persons who received help on their medical bills from Kerr-Mills increased from 46,247 in 1961 to 114,657 last year. And the amount of money spent on this program rose from $9.3 million a month to $24.2 million—or almost $300 million for the year.

The number of persons served admittedly was not large as compared with the total need. But it was 2½ times as large as the number helped the previous year—which suggests that states generally are only just waking up to the fact that there is a Kerr-Mills act on the federal statute books.

The administration obviously is not out to sell Kerr-Mills. Rep. Byrnes (R-Wis.) goes so far as to say that it "has been not only dragging its feet on encouraging state participation in Kerr-Mills but has actually put stumbling blocks in the way of its success."

Kerr-Mills is a state-directed program—which may explain why the administration is not even lukewarm toward it. But not all the blame for the halting start it has made can be laid at the White House door. The 30 or more states that haven't acted to participate must share a large part of the blame. Most of them are eternally complaining about having Washington usurp their powers. Kerr-Mills offers them a chance to take care of the medical problems of their most needy citizens under a joint federal-state program and they are looking the other way.

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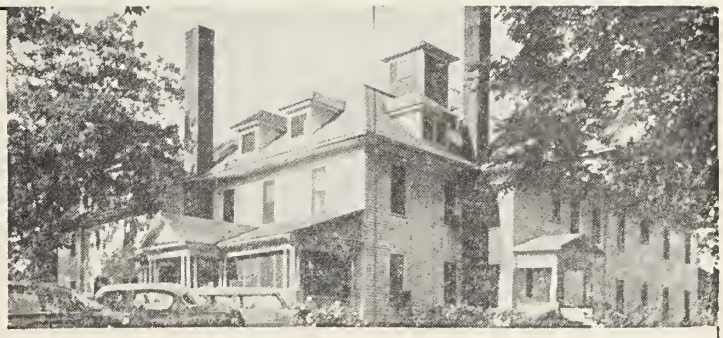
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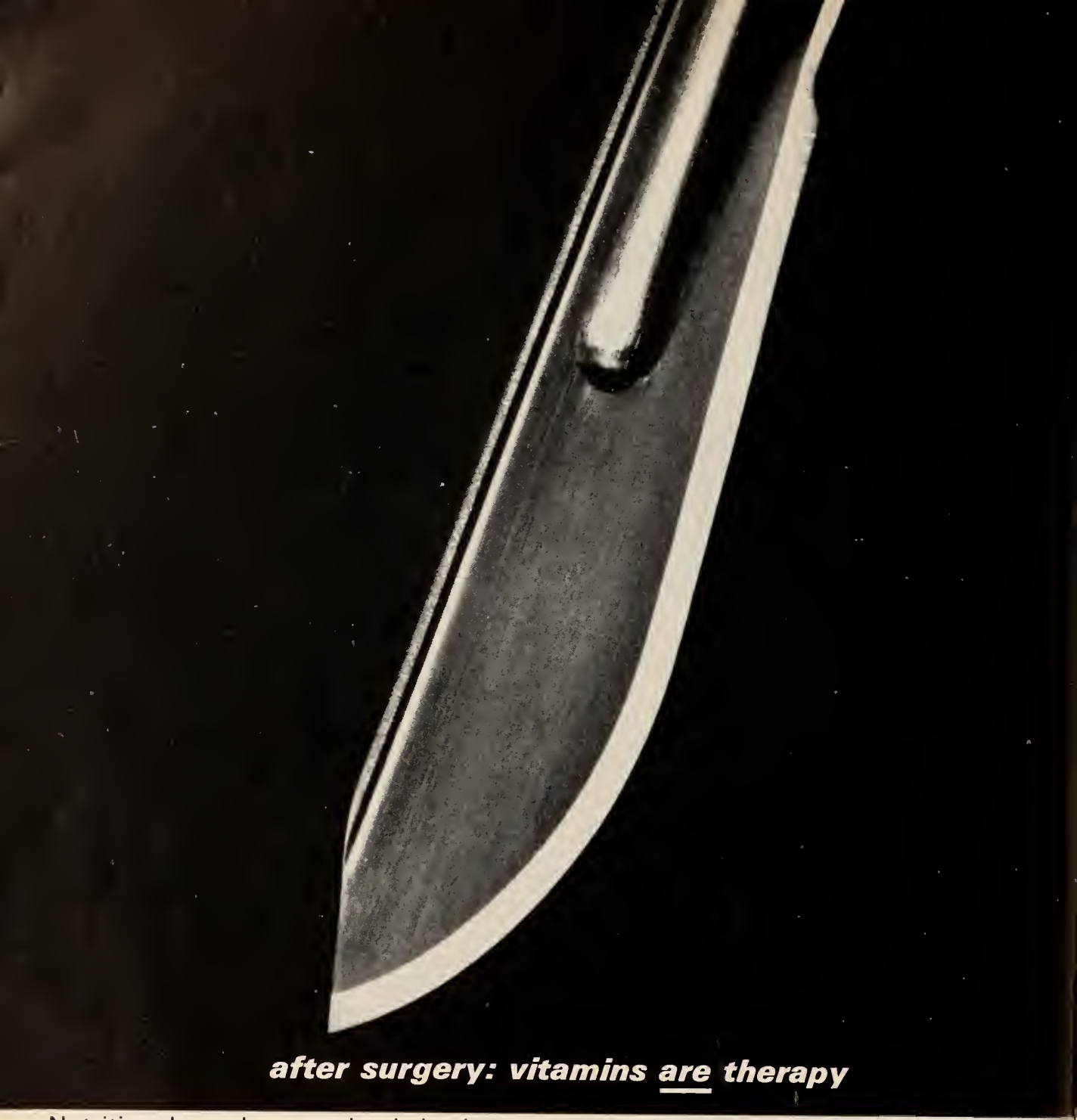
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Although the prognosis in Friedlander's pneumonia is poor, treatment with CHLOROMYCETIN has shown a good response when susceptible strains of *Klebsiella pneumoniae* are incriminated.

In *Hemophilus Influenzae* Pneumonia[3,4,13,14]

Because the invading organism is usually sensitive to CHLOROMYCETIN, this agent is generally effective in pneumonias caused by *H. influenzae*.

In Staphylococcal Pneumonia[1-8,13]

CHLOROMYCETIN continues to remain effective against many resistant strains of staphylococci, and—alone or in combination with other antibiotics—should be considered when other antistaphylococcal drugs are ineffective.

In Acute Epiglottitis[4,10,11]

This condition is most often caused by *H. influenzae*, most strains of which are sensitive to CHLOROMYCETIN. Therapy should be instituted at once, since the disease may progress from the first symptoms to a severe respiratory obstruction in four to six hours.

In Pneumonias Due to Gram-negative Bacilli[9]

Because of its broad-spectrum activity, CHLOROMYCETIN is often effective in pneumonias caused by sensitive strains of *Aerobacter, Proteus* of various species, *Paracolobactrum,* and other gram-negative pathogens encountered with increasing frequency in serious respiratory tract infections.

In Staphylococcal Empyema[12]

The infiltrating lesions of staphylococcal empyema are often difficult to eradicate. While CHLOROMYCETIN should only be used when the infection has been resistant to treatment with other antistaphylococcal drugs, therapy with CHLOROMYCETIN, in conjunction with surgical procedures, will often bring favorable results.

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Volume 62 Number 4

April, 1963

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THE COVER

The scientific articles in this number focus on Cancer, and the cover appropriately uses the Crab, the Zodiac sign for Cancer. The special Cancer articles begin on Page 371.

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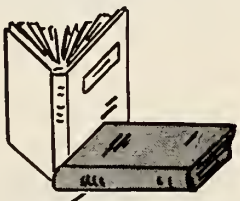
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Recent advances in the area of medical genetics have required a complete rewriting for this revision. New chapters cover *Cancers, The Chromosome Breakthrough,* and the *Environment.* The wealth of counseling experience available to the author has grown to over 2500 "cases," all handled at the Dight Institute for Human Genetics.

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President's Page

HELP YOUR CONGRESSMAN



Clarence D. Owen

President

Michigan State Medical Society

With HR 3920 before the Congress, it seems appropriate to devote this President's Page to a discussion of "How to Assist Your Congressman."

If you don't now recognize "HR 3920"—you will. That is the number of the bill introduced into the House of Representatives by Representative Cecil R. King, California Democrat. The companion bill introduced into the Senate by Senator C. P. Anderson, New Mexico Democrat, is S 880.

The bill this year is titled "Hospital Insurance," but the aim is the same as last year—"to provide under the Social Security program for payment for hospital and related services to aged beneficiaries."

Once again, as Congressmen weigh the merits of these proposals, they will depend upon you for your views and advice. If you have never helped your Congressman come to decisions that reflect the will of the people back home, you must start now. You may be his best and only source of information on some subjects of vital concern to both you and your Congressman. Surely, this is true in the field of health and medical care.

Hundreds of bills are introduced every year in Washington with health and medical overtones. Your training and experience make you the logical person to help your Congressman deal with these matters. You can provide him with honest, forthright opinions; you can give him new information; you can help relay the views of your patients at the grass-roots level; you can tell him how other community leaders feel.

There are many ways that you can be more helpful to your Congressman. You should follow his career and know how he votes on various issues. You should keep informed—attend meetings, read, study, participate. You must know the facts to provide dependable help to your Congressman.

Specifically, you can write to him. Your letters should tell him, in a clear-cut manner, how you see certain bills. Your letters should supply arguments and examples for supporting or opposing specific bills. Your letters can urge him to speak and vote for or against the bill in committee or on the floor.

Let me close by being specific about the new HR 3920 (or S 880): Have you read the bill? Have you studied the analysis made by the AMA? Do you know about the changes made in this 1963 version over the 1962 King-Anderson scheme? Have you asked your MSMS officers and staff members to clear up any questions you might have?

Are you informed?

Are you helping your Congressman—and your neighbor, too—to make the right decisions?

MSMS Clinic Days Set For Spring



The Michigan State Medical Society's "Clinic Days" will be held in 19 Michigan communities during April, May and June.

The Spring series is sponsored by the MSMS Postgraduate Medical Education Committee, chaired by John M. Sheldon, M.D., Ann Arbor. Cooperating to make the postgraduate programs possible are the University of Michigan, Wayne State University and the Michigan Department of Health.

Each member is welcome to attend the program nearest his home community. The attendance last year for the fall and spring meetings was 916, a good gain over the 772 from the preceding year.

The programs will stress diagnosis and treatment and provide information about recent advances. Local patients will be used when possible. The names of the speakers and their topics will be mailed to each member.

Following is the schedule of Spring extramural courses, alphabetical by community:

Alpena— Thursday, May 23
Battle Creek — Tuesday, May 7
Bay City — Wednesday, May 22
Cadillac — Wednesday, May 22
Grayling — Wednesday, April 10
Jackson — Tuesday, April 16
Lansing — Tuesday, May 21
Midland — Friday, May 17
Muskegon — Friday, May 24
Niles — Tuesday, May 21
Petoskey — Thursday, May 9
Port Huron — Tuesday, June 11

Upper Peninsula

Calumet-Houghton — Wednesday, May 15
Escanaba — Tuesday, May 14
Iron Mountain — Thursday, May 16
Ironwood — Tuesday, May 14
Marquette — Thursday, May 16
Menominee — Wednesday, May 15
Sault Ste. Marie — Monday, May 13

MSMS Maternal Health Committee To Sponsor Seminar at Gull Lake

The MSMS Maternal Health Committee will conduct a Maternal and Perinatal Welfare Seminar at the Michigan State University Conference Facility, Gull Lake, Hickory Corners, May 23-24. The conference last year was such a success that those who attended voted to meet again in '63 at the same location.

A stellar program is being arranged with attendance limited to 100. Interested participants are urged to write to Michigan State Medical Society, Box 152, East Lansing, to make an early reservation. Copy of the program will be mailed as soon as available.

The arrangements are being directed by W. W. Jack, M.D., chairman of the MSMS Maternal Health Committee.

Wickliffes Open Medical Center In California

Newspaper clippings from the Copper Country of the Upper Peninsula show the handsome, $200,000 Medical Center erected in Escondido, California, by T. P. Wickliffe, M.D., former Vice-Chairman of The MSMS Council, and his two sons, Charles and Robert, both doctors of medicine. The handsome two-story building provides offices and other facilities for five physicians. It is a medical center and not a clinic—each doctor is entirely independent but each has access to the general facilities.

Doctor Charles Wickliffe is president of the business corporation that erected the building.

Doctor T. P. Wickliffe's address is 1211 East Pennsylvania Avenue, Escondido, California.

Doctor Owen Honored

Recently a testimonial dinner by the staff of the Grace Hospital, Detroit, honored C. I. Owen. M.D., MSMS president, upon his retirement as pathologist and director of laboratories at Grace for more than 41 years.

Toastmaster for the event was Milton Darling, M.D., a past president of MSMS.

Doctor Owen's efforts to develop the outstanding laboratories at Grace were praised by T. K. Haven, president of the hospital board; Chief-of-Staff E. S. Gurdjian, M.D., and others.

Michigan Medical Meetings

Western Michigan Trauma Meeting, April 17, Muskegon.

Harper Hospital Centennial, May 1-2-3, Detroit.

Wayne University Medical Alumni Clinic Day, May 8, Sheraton-Cadillac, Detroit.

Kent Health Fair, May 19-24, Grand Rapids.

Michigan Health Council State Conference, May 21-22-23 Pantlind Hotel, Grand Rapids.

Michigan Kidney Disease Foundation — Second Annual Renal Disease Symposium, May 25-26, Ann Arbor.

MSMS Maternal and Perinatal Welfare Seminar, May 23-24, Kellogg Biological Station at Gull Lake, Hickory Corners.

Upper Peninsula Medical Society, June 28-29, Sault Ste. Marie.

Coller-Penberthy Clinic, July 25-26, Traverse City.

MSMS Annual Session, September 25-26-27, Grand Rapids.

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829 Croix Street
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Orthopedic Surgery

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Grand Rapids 8, Michigan
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Gwinn, Michigan
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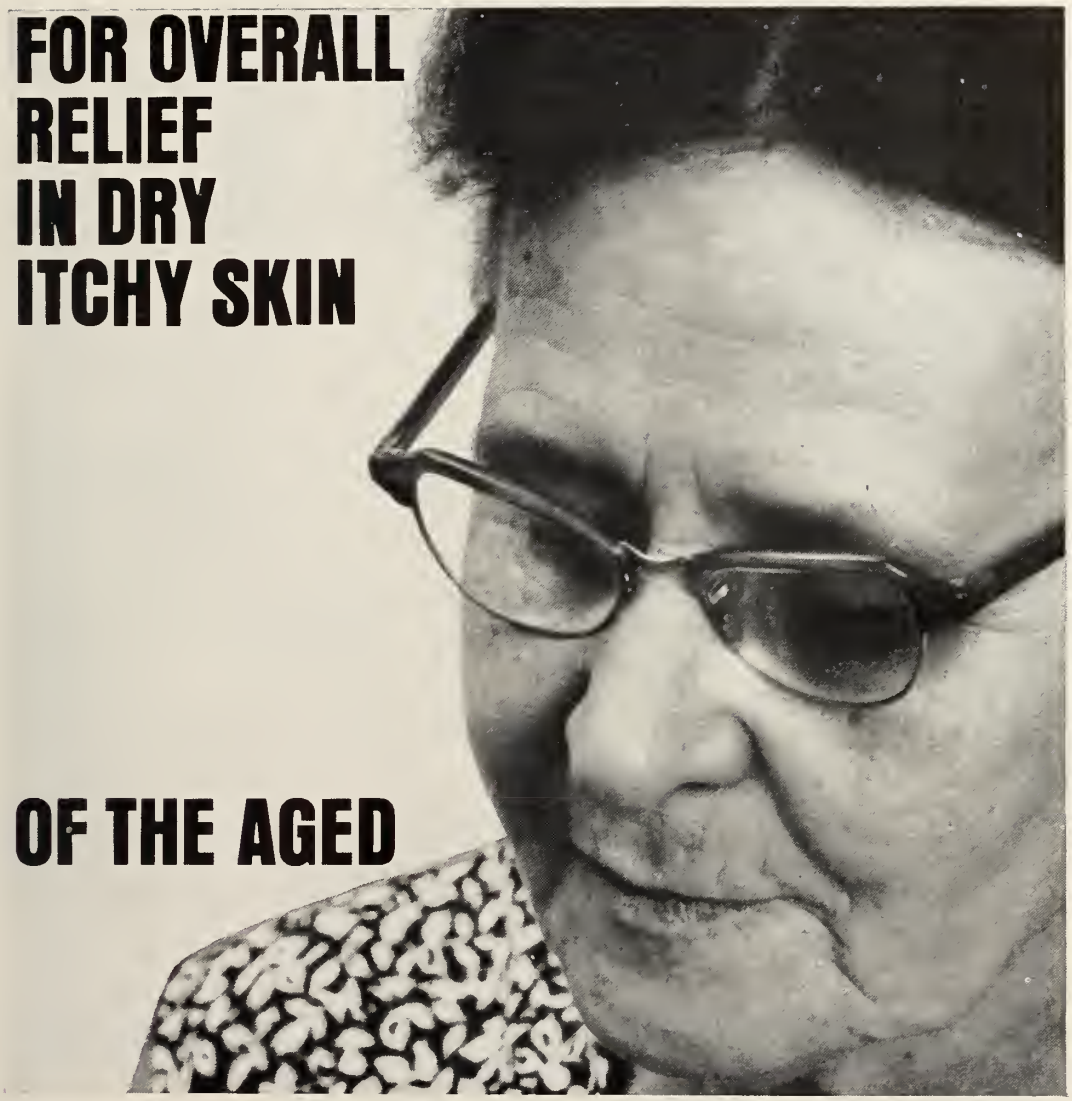
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1. Borota, A., and Grinell, R. N.: J. Amer. Geriatrics Soc., 10:413, 1962. 2. Spoor, H. J.: N. Y. State J. M., 58: 3292, 1958. 3. Lubowe, I. I.: Western Med., 1:45, 1960. 4. Weissberg, G.: Clin. Med., 7:1161, 1960. 5. Lieberman, W.: Amer. J. Proctology, 12:374, 1961. 6. Dick, L. A.: Skin, 1:341, 1962.

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Here is the first cardiac monitoring system, with alarms and pacemaker, to provide an *integral electrocardiograph* — that can be set for automatic ECG recordings at either selected intervals, at the onset of any of four distress conditions, or *while the patient is being paced.* Characteristic Sanborn operating advantages are reflected throughout the design of the new Model 780 Viso-Monitor — in the *amount* of useful information presented and the *completeness* of controls and operating modes to meet individual patient needs. ■ The four basic functions of the Viso-Monitor are provided by these built-in facilities: *direct-writing electrocardiograph* of proven design, with added marker stylus to record digital pulse and to distinguish between "programmed" ECG's and "distress" ECG's; front panel *heart rate meter* with adjustable upper and lower limits; *visual alarms* by indicator lights for tachycardia, bradycardia, arrest, no pulse, QRS complex — plus instrument operating conditions (power, pacing, inoperate); and a *pacemaker* for internal or external pacing, operated manually or set for automatic pacing at arrest, with controls to preset pace current and rate. ■ For simultaneous *visual and audible alarm,* the 780-800 Remote Indicator displays heart rate and the 8 events as on bedside Viso-Monitor, plus a "beep" at each QRS complex and steady tone if distress occurs. Indicator lights remain on until reset at main unit. The Viso-Monitor may also be connected to the hospital call system, for an additional means of display and warning. ■ Model 780 Viso-Monitor $1850, Model 780-800 Remote Indicator unit $250, F.O.B. Waltham, Mass., continental U.S.A.



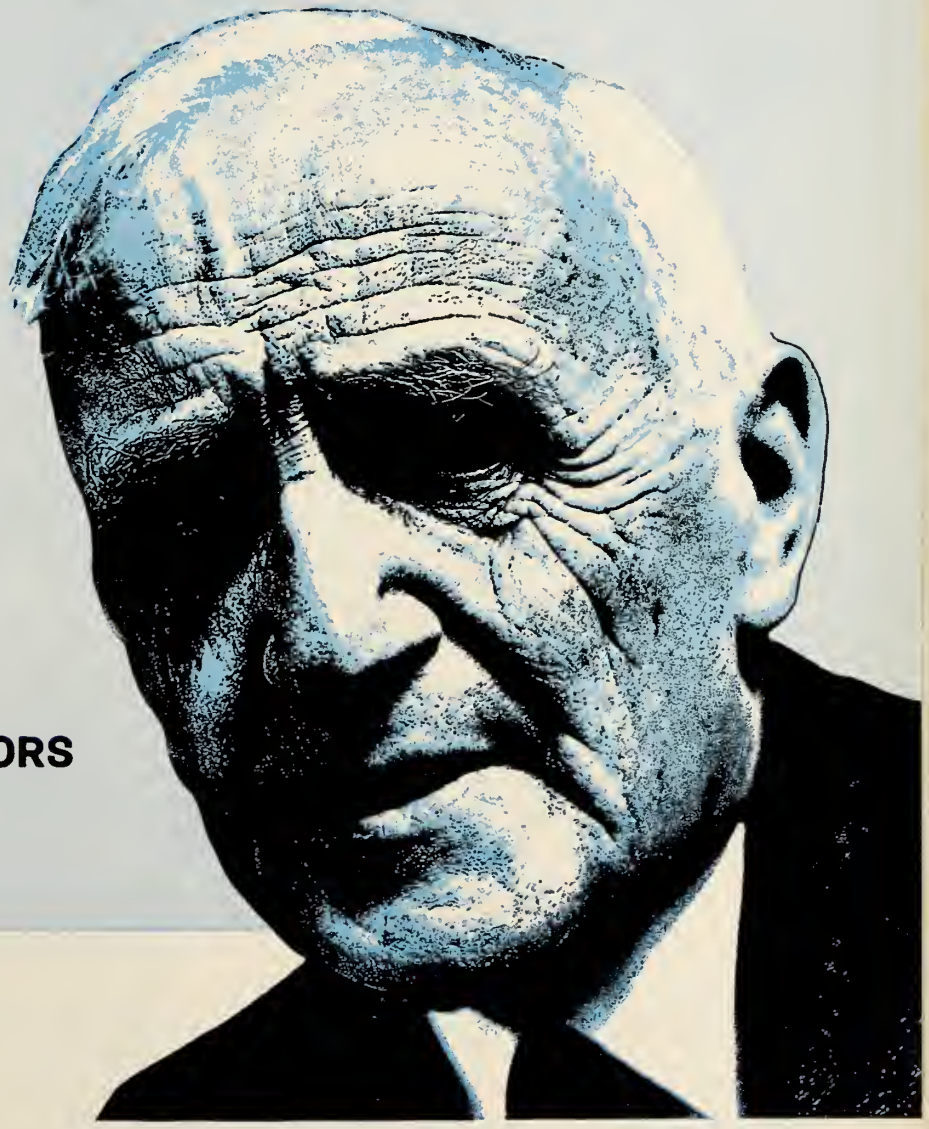
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Soma relieves stiffness —stops pain, too

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HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

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Doctors, Wives Continue To Help Carver School

The excellent community service project of the Oakland County Medical Society and its Women's Auxiliary to help the Carver School students and parents is continuing. (Carver School is a elementary school located in an area of low-income families.)

The project dates back to 1961. In December of 1961 approximately 70 physicians from the Oakland County Medical Society did 700 physicals on the students of Carver School. Complete laboratory work was done by technicians from three hospitals, Wm. Beaumont, St. Joseph Mercy and Pontiac General. The necessary follow-up work was done in physicians' offices and various hospitals at no cost to the patients.

In January of 1962, the Oakland County Medical Society asked the Auxiliary to help the school by participating in an adult education type program by providing medical transportation, and by collecting used clothing from our members.

Auxiliary members have transported both children and adults from their homes to the Public Health Department for chest x-rays and Tuberculin Patch tests. Transportation also has been provided to and from hospitals, clinics and doctors' offices.

The Auxiliary has delivered five station wagon loads of clothing. The Carver School PTA has undertaken the job of mending serviceable clothing.

The adult education program consists of modest daytime informal classes on subjects the parents have requested.

Last spring, in conjunction with Area Service Association and Cooperative Extension Bureau, a series of classes was given which included areas of nutrition, marketing, budgeting, sewing, etc. Those completing the series were given certificates of participation which were received with great pride.

The Auxiliary helps to provide speakers on such subjects as hat making, home nursing, sewing and alterations, cooking for a group, correctly setting a table, remedial reading, arts and crafts. We are attempting to supply the teachers and form these classes.

"The aim of this project is to help the parents of the Carver School area help themselves and assume more personal responsibility for volunteer services; and the establishment of a broad public health program for students and their families," explains Mrs. Edwin J. Westfall, president of Oakland Auxiliary.

Assures County Societies Handle Complaints Promptly

The fair, effective work of county medical society committees that review complaints of patients was discussed when the MSMS representative appeared before the Michigan Insurance Commissioner's recent hearings on Blue Cross-Blue Shield rate requests.

O. K. Engelke, M.D., immediate past president of MSMS and now legal affairs committee chairman, declared in part—"Whenever anyone feels that he is either unfairly or improperly treated by a physician he can, and should, take his complaint to the doctor's county medical society where it will receive prompt, thorough evaluation."

Doctor Engelke assured that "The county medical societies in Michigan will always take appropriate steps to see to it that legitimate, specific complaints are thoroughly checked and misunderstandings are explained wherever possible."

"The medical profession welcomes the opportunity to investigate specific cases," Doctor Engelke declared. He added, "Generalized complaints of improper medical practices and needless hospital use will be found to be grossly exaggerated."

Washtenaw Judges Hear Alcoholism Panel

Judges of Washtenaw County were special guests at a recent Washtenaw County Medical Society meeting on "The Treatment of Chronic Alcoholism." A panel, moderated by Robert A. Moore, M.D., included Melvin Selzer, M.D., B. C. Payne, M.D., all three of Ann Arbor, and Donald Damstra, M.D., of Brighton.

Wayne Offers Speakers on Medical Careers

The Medical Recruitment Committee of the Wayne County Medical Society introduced a new program at a recent meeting of approximately 40 high school counselors in Wayne County. At the meeting, it was announced that a "Speakers' Bureau on Medical Recruitment" has been set up in order to accommodate requests from groups interested in careers in medicine and para-medical fields. This idea was conceived by the Alumni Association of Wayne State University Medical School to stimulate the interest of high school students in choosing a medical career.

At the conference with the counselors, President Ralph R. Cooper, M.D., of the Wayne County Medical Society set the pace with a stimulating welcome address, followed by Dr. Morton Levitt's talk on the Pre-Medical and "2-4-2" programs at Wayne. Dean Gordon Scott discussed the Basic Science program, and Dr. George Clifford spoke on the Clinical Sciences. Information concerning Internship and Residencies was presented by C. J. France, M.D.

The Alumni Association of Wayne Medical School hopes to work with other county medical societies in establishing similar programs for medical recruitment.

WSU Medical Library Prints Comprehensive Guide

The Wayne State University College of Medicine library has compiled a bibliography listing the titles of its bio-medical periodicals and those available in 11 industrial and hospital libraries in the Detroit area. The new guide will be distributed to medical libraries and WSU medical faculty as a reference aid for doctors and others engaged in research. The bibliography, made possible through the cooperation of several libraries in the community, is the first such joint effort in several years.

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*Schiller, I. W. and Lowell, F. C.: New England J. Med. 261:478, 1959. A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

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solid results!

This is the kind of response you can expect with Robinul therapy.

Because Robinul's anticholinergic action is so specific, so intense, and so consistent, it provides a favorable internal environment for ulcer healing.

Positive suppression of gastric acid volume. Moeller[1] demonstrated that 2 mg. of Robinul decreases the volume of HCl secreted by 73% within one hour and 85% within two. Epstein[2] described Robinul's "intensive antisecretory action" as "exemplary."

Significant increase in gastric pH. In his studies comparing the effect of anticholinergics on gastric pH, Sun[3] found that the optimum effective dose of Robinul "... produced suppression of gastric acidity to pH 4.5 or higher in all 16 patients examined." Posey[4] reported "an excellent reduction of gastric acidity ... in 12 of 15 patients...."

Desirable antimotility effect. Young and Sun[5] found that although Robinul (given subcutaneously) demonstrated its ability to suppress antral motility, a 2 mg. oral dose "did not affect gastric emptying or intestinal transit time" in six patients with duodenal ulcer.

New freedom from side effects. Robinul has shown that an anticholinergic need not be plagued with a high percentage of side effects. Of 1705 patients in clinical investigations, many of whom were studied on above-normal doses, fewer than 7% experienced side effects of a moderate-to-severe degree, with only 3% requesting discontinuance of the medication.

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REFERENCES: 1. Moeller, H.C.: Ann. New York Acad. Sc. 99:158, Feb. 28, 1962. 2. Epstein, J. H.: Am. J. Gastroent. 37:295, 1962. 3. Sun, D. C. H.: Ann. New York Acad. Sc. 99:153, Feb. 28, 1962. 4. Posey, E. L., Jr.: Am. J. Digest. Dis. 7:863, 1962. 5. Young, R., and Sun, D. C. H.: Ann. New York Acad. Sc. 99:174, Feb. 28, 1962.

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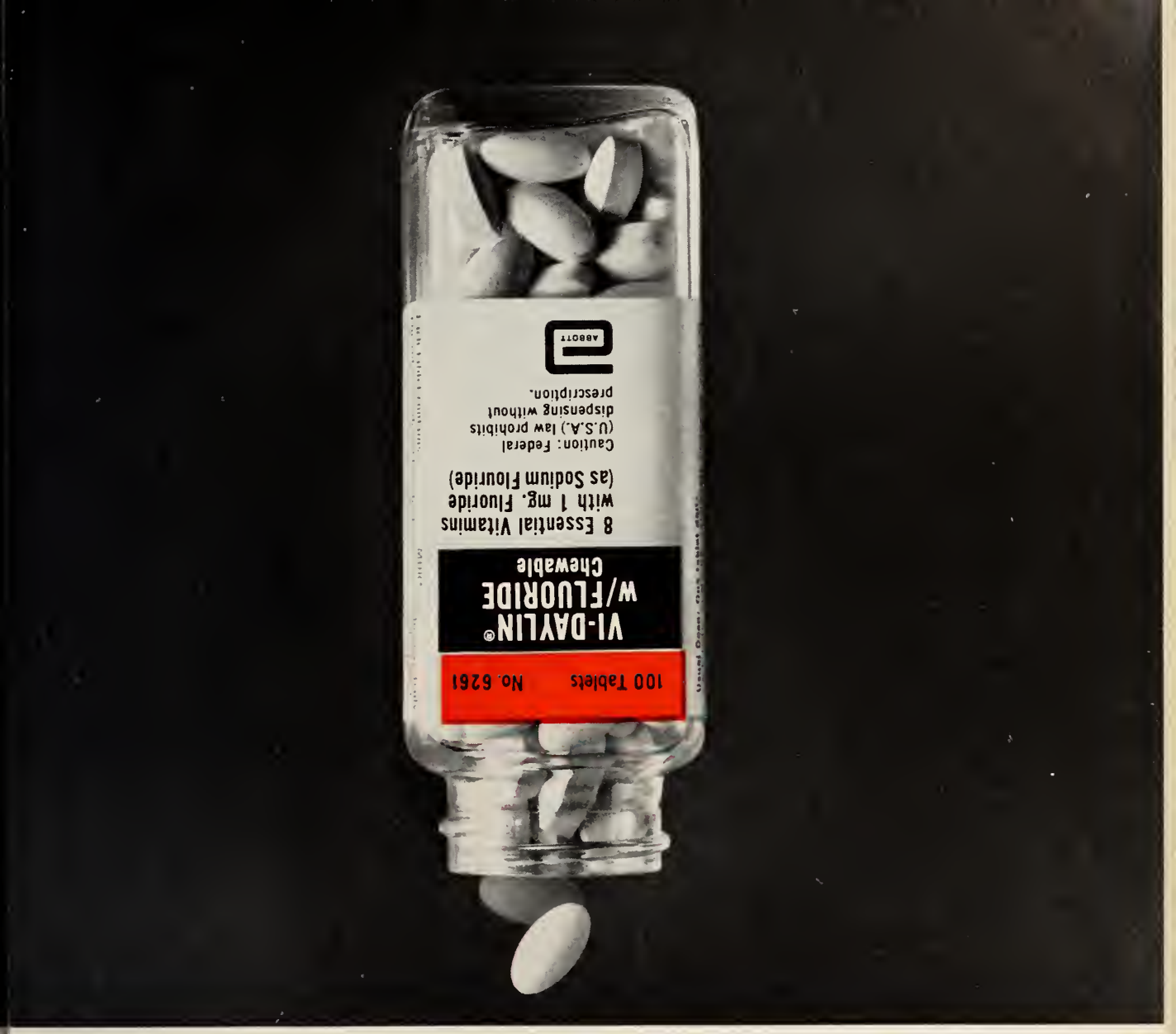
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3. Sweetened with sugar-free Sucaryl®. Because Sucaryl is non-nutritive, it will not react with bacteria to form acids in the mouth.

Cost? No more than regular Vi-Daylin Chewable in economical bottles of 100.

75TH ANNIVERSARY ABBOTT

1. Prescribing Supplements of Dietary Fluorides, Council of Dental Therapeutics, J.A.D.A., 56:591, April, 1958.
2. Fluoride Compounds, Accepted Dental Remedies, 27th Ed.:139, 1962.

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Poythress, White Section, Page 808 (1963 edition) and Product Identification Section

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Says "Facts Won't Speak For Themselves"

"Facts don't speak, only people do."

That advice was given at the annual conference of the Michigan Health Council by Robert Haakenson, M.D., of Smith Kline and French Laboratories, Philadelphia.

Members of the Michigan Health Council were urged to overcome the relatively poor opinion some people have of the health care team by doing a better job of telling their story to the public. "The facts won't speak for themselves," he stressed.

Doctor Haakenson cited the prescription drug industry as an example of how "a failure in communication" had hurt a member of the health care team. "Before the investigation of the drug industry (by Senator Kefauver's Subcommittee on Antitrust and Monopoly), we makers of prescription drugs had felt little need to explain ourselves and our function to the public because we dealt directly with physicians and pharmacists. Consequently the public knew very little about us," Doctor Haakenson said.

Doctor Haakenson emphasized that it is especially important for all members of the health care equation—drug producers, druggists, physicians and public health officials—to get their story across in a truthful, straightforward way at every opportunity.

All members of the health team are vulnerable to attack from many quarters, he said, and therefore, all have an interest in creating the best possible image.

"There are no real secrets to communication," he concluded.

"A message should be simple, direct, truthful and expressed in terms that the audience will understand, whether we use the written or spoken word. The best communication is, of course, person-to-person."

"It's a hard, trying, often unpleasant job to say things simply and truthfully, but if we are to convince people that our system of health care is worth keeping, this is what we'll have to do."

Thorazine® *is not an analgesic*

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but it can help you relieve the suffering of your patient in PAIN . . .

by reducing the anxiety and fear that intensify pain

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Photograph professionally posed.



Health Care Spending For Detroit Reported

By Richard M. Campau,
MSMS Research Director

New data on what percentage of take home pay families in seven large metropolitan areas spend on health care has recently been made available by the U. S. Bureau of Labor Statistics.

For its health care needs, the average big city family now annually spends amounts ranging from slightly over $300 in Atlanta to over $400 in New York.

As can be seen in the following table the average amount spent for health care per family in Detroit for 1960 ranked in the middle of the seven cities surveyed.

	Average Spending for Health Care Per Family 1960		*Average Income Per Family After Taxes* 1960
Atlanta	$308	5.7% of	$5,412
Boston	321	4.7% of	6,869
Washington, D. C.	339	5.0% of	6,838
Detroit	367	5.9% of	6,226
Chicago	376	5.5% of	6,857
San Francisco	393	6.4% of	6,154
New York	431	6.4% of	6,708

Other statistics from the U. S. Department of Commerce reveal that in 1961 Americans spent $338 billion on their personal needs.

Of this total, $21.1 billion was spent on medical care. About the same amount was spent on recreation—$20.6 billion. In addition, $10.2 billion was spent on alcoholic beverages, tobacco products accounted for $7.6 billion, and personal business items which include bank service charges, legal service, investment counselling fees, and interest charged on personal debts, accounted for $21.6 billion. All four of these categories added up to $60 billion in public expenditures —or some 17.8 cents out of every dollar spent by the public—and nearly three times the expenditures for medical care.

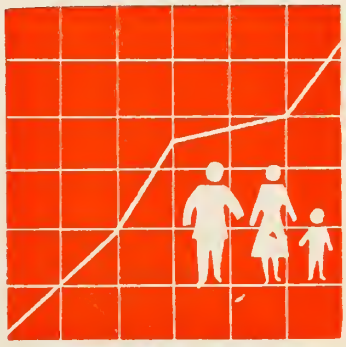
Other personal expenditures in 1961 included $71 billion for food, $44 billion for housing, $40 billion for transportation, and $34.5 billion for clothing, accessories and jewelry.

Taken as a proportion of all personal spending, medical care expenditures have not increased sharply in the past 20 years, especially when the great progress made by medical science is taken into consideration.

Doctors Get 27.6 Cents of Consumer Health Dollar

Physicians received 27.6 cents of every consumer dollar spent for health care during 1961—according to recent figures by the Social Security agency.

A further breakdown of the consumer's health dollar shows 27.6 cents also for hospital care; 19 cents for drugs; 9.8 cents for dental care; 6 cents for eyeglasses and appliances; 4 cents for nursing and



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other professional care; 1.4 cents for nursing-home care. The remaining 4.6 cents represented the net cost of health insurance.

The physician's share of the medical dollar was 31 cents in 1941.

The Social Security Administration reports that American consumers spent a new high of $21.1 billion for health care in 1961. This total included $14.4 billion in direct out-of-pocket expenditures and $6.7 billion paid for health insurance. The 1961 total exceeded by $1.3 billion the total spent in 1960.

The 1961 consumer expenditure for health care amounted to $116.80 for each American. Direct expenditures per capita were $79.76 and payments for health insurance amounted to $36.84 per capita.

These sums applied only to private expenditures for health care and did not include government outlays or health care provided through private organizations to the needy.

Of the total $6.7 billion expenditure for health insurance premiums, 45.4 per cent was paid to Blue Cross-Blue Shield plans, 38.1 per cent to insurance companies for group coverage, 9.4 per cent to insurance companies for individual policies, and 7.1 per cent to independent health insurance plans.

It was estimated that insurance benefits paid 28.3 per cent of the consumer's total 1961 health care bill, exclusive of the cost of insurance.

Insurance met 66 per cent of all charges for hospital care, 30 per cent of all charges for physicians' services, and 1.5 per cent of the cost of all other items, including dental care, nursing service, drugs, and nursing-home care.

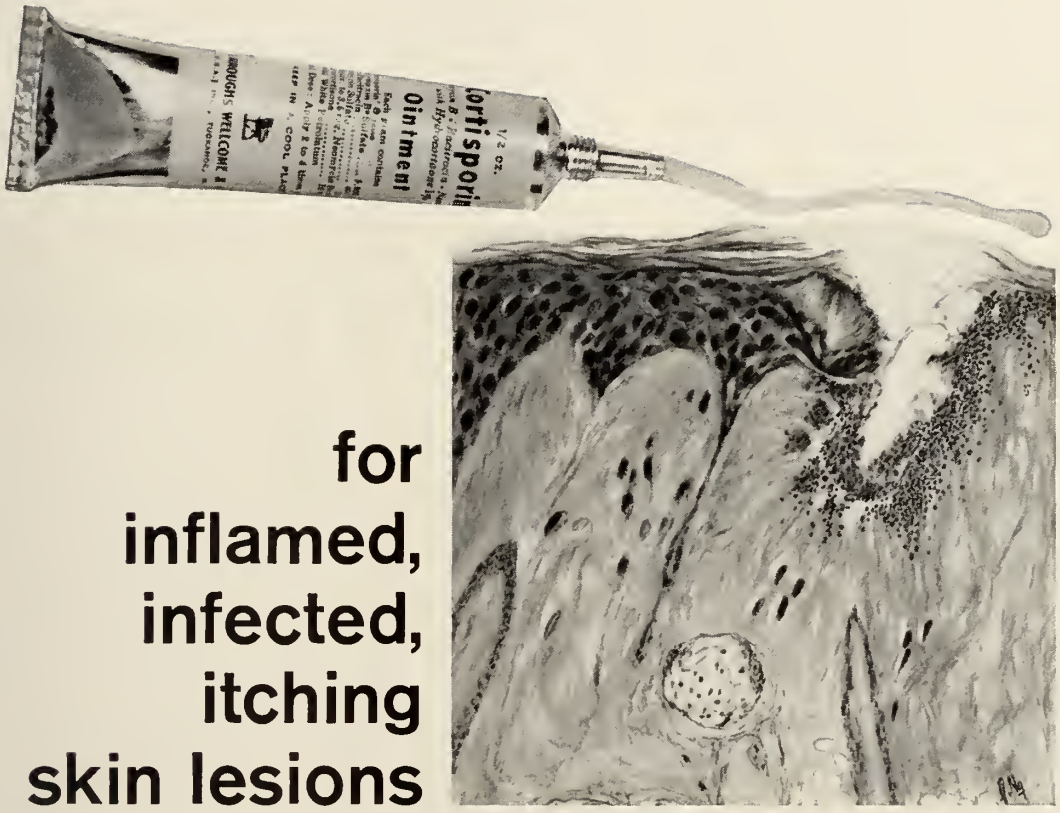
Says Aloofness Must Go

The theme of the 1961 National Health Council Meeting in New York last March was "Better Communication for Better Health." In his talk at this conference, Cornelius H. Traeger, M.D., editor, *Medical Radio System*, R.C.A., said:

"The doctor must discover a new kind of dignity—not based on pretense. He must cease to be an aloof 'medicine man.' The patient wants to be allowed to participate. He doesn't want to be treated as a medical illiterate. The patient is going to other sources for information only because he is not getting it from doctors. Medical people should disseminate knowledge themselves, rather than leave it to others to do it.

"A basic change in the doctor's attitude is necessary. The doctor must recognize that he lives in a changing world; one in which people don't want to be condescended to; people don't just want to have their disease cured—they want a permanent relationship with their physicians; they don't want a 'general practitioner'—they want a 'personal physician.'"

Say you saw it in the Journal of the Michigan State Medical Society



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- relieves pain and itching
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- rarely sensitizes

General Indications: Wherever inflammation or infection occurs and is accessible for topical therapy, as in burns, wounds, skin grafts; and plastic, proctologic, gynecologic, or general surgical procedures.

Dermatologic Indications: Atopic, contact, stasis, infectious eczematoid, and lichenoid dermatitis; neurodermatitis, eczema, pyoderma; anogenital pruritus; primary dermatoses with or without secondary infection; external otitis.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms.

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Each gram contains:

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Zinc Bacitracin	400 Units
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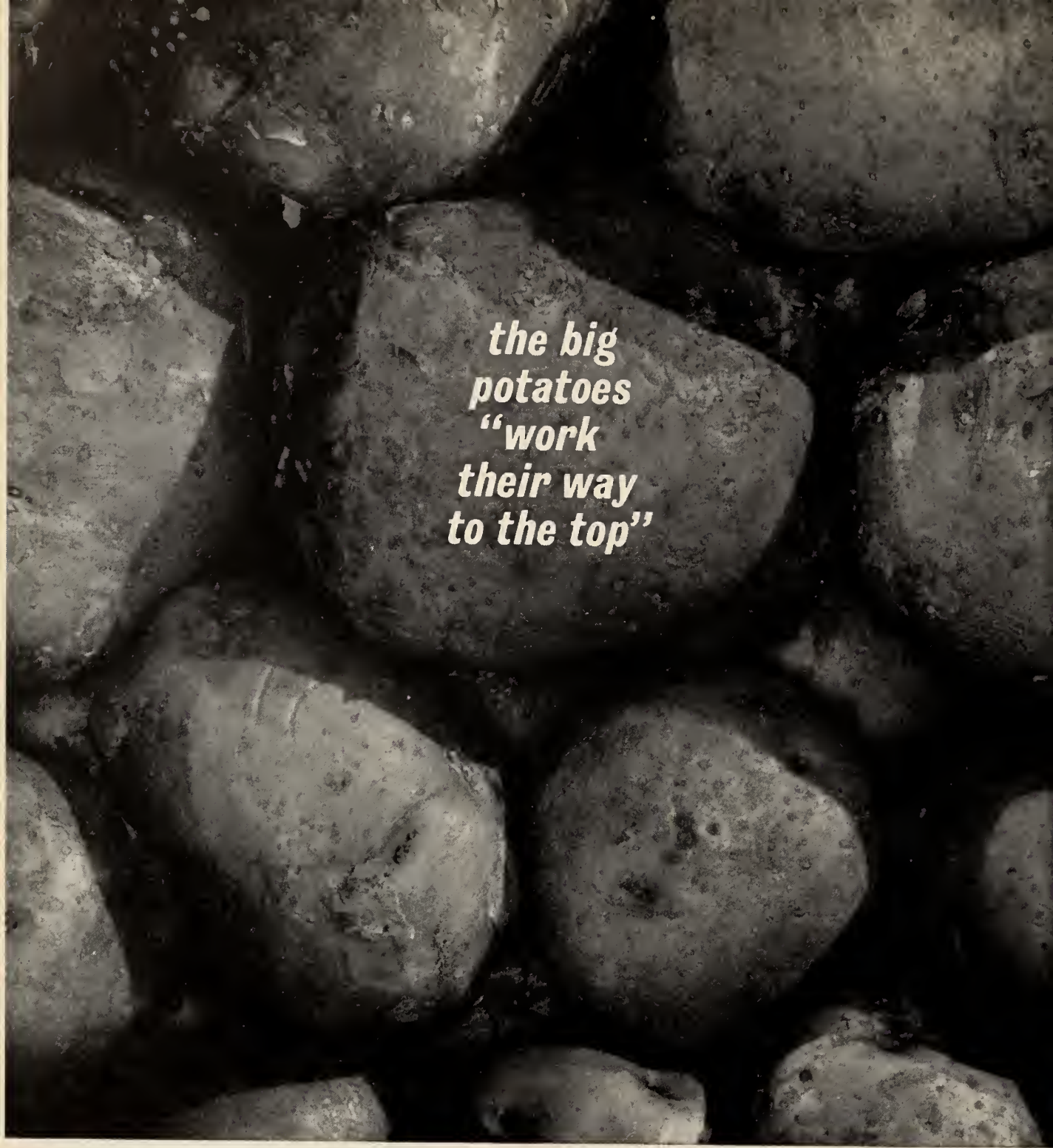
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Curing Cancer with Radioisotopes

(And in Darkest Africa, too)

Marshall Brucer, M.D.
Tucson, Arizona

THERE is one way to cure cancer. Get rid of it!

There are many ways to accomplish the cure. The proper way depends upon your individual bias. Prayer is considered a good cure in some circles; however, it is limited to a rather restricted clientele. Various forms of witch doctoring have had more or less success, depending upon the observer. Eugenics and euthanasis are somewhat related methods. They are certainly complete cures. The genetic methods, however, work well only in mice. Euthanasia, though absolute, is illegal and unmedical; it can be recommended only for somebody else.



Chemotherapy

Chemotherapy seems to be more adaptable to the Mashullach (for the non-Jewish, this means fund raiser) than it is to the scientist. The *New York Times** is the best place to find various chemotherapeutic cancer cures. On February 19, 1915, the *Times* announced that General Memorial Hospital used a new serum with success. On September 6, 1920, the *Times* reported that gland injections were not new; results had been reported 15 years previously. On May 14, 1930, they reported a cure of cancer in rats with low oxygen environment. On December 18, 1935, they reported evidence that the entrails of sheep contained a hormone that was preventive of cancer. On June 16, 1940, they reported the successful use of yeast as a cure for cancer in mice. On August 17, 1955, there was a report of 20 patients as proof of effective chemical control by lipids. This is only a small smattering of reports. You can find similar statements any year since the *New York Times* started in 1851. The language changes, but the idea is always the same. To quote a radiotherapist, "Mustard is for hot dogs."

Surgery

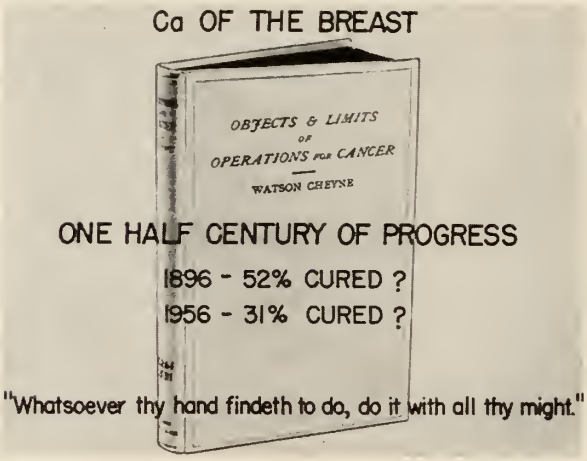
Another cure for cancer, and probably the best cure for those of us who are prejudicial to western medicine, is surgery. But surgery doesn't always work. Sometimes it fails. However, on December 20, 1925, the *New York Times* reported a gain in cures through treatment in early stages. This is an argument that can't be beat. If you catch a cancer early enough, you can cut it out. If you don't

*I quote the *New York Times* merely because I have read it since 1851. It is available, not vulnerable.

cut it all out, you didn't catch it early enough, because if you catch it early you can cut it all out.

Radiation

Radiation is another acceptable cure for cancer. An obituary on January 5, 1915, in the *New York Times*



reports the cure of a cancer of the tongue by radium. The reason for the obituary was because the man died of throat cancer, but he was cured of the cancer of the tongue. The controlled use of radiation is a 20th century phenomenon. The daily press has duly chronicled the fables and foibles of the radiation cure for cancer throughout the century. On January 1, 1915, the *Times* reported the first radium operation for cancer at Bellevue Hospital. In spite of the many cures that have been performed, radioisotopes (radium is a radioisotope to all except the newspapers) are remarkably free from Mashullach distortion. This was true for almost a half century. But then on August 3, 1946, the *New York Times* reported "from the ghastly chambers of death at Oak Ridge" that a $400 speck of carbon-14 was sold by the government to help find a cancer cause. The first shipment went to St. Louis. Then on August 6, 1946, the first shipment went to the University of Pennsylvania. Then on August 11, 1946, the first shipment went to the University of Minnesota . . . the University of California . . . the University of Chicago. The historical accuracy depends upon whose campaign you are interested in. Perhaps the last completely honest newspaper statement appeared in the *New York Daily Times*, Saturday, June 11, 1853—"We have Bermuda papers to the 31st of May. No news in them . . ."

The Word "Cure"

But radioisotopes have produced some cures of cancer and they may have produced quite a few depending upon how you twist the word "cure." The word is peculiarly susceptible to twisting. The illustration is probably an example of the twist—we hope. A cure is always a good thing. It has lots of positiveness to it. When the word "cure" is linked with the word "motherhood," it is second only to "finding the cause for" in the headline hunting game. After all, once we found the cause for tuberculosis we almost automatically found the cure. (The intervening 80 years is insignificant in geologic time.) Dr. Samuel Seidlin accomplished the first radioisotope cure of a patient with thyroid cancer in 1942. The patient outlived the doctor, but he died of another disease about a decade later. The terminal leukemia might have been caused (?) by the radioiodine. Was Dr. Seidlin a physician or was he a murderer? Was the patient cured? Dr. Seidlin thought so. The patient thought so. But some geneticists point out that the patient was ruined by radiation as a childbearing entity. (The patient was already a grandfather but didn't bear any further children—it's true!)

Back in 1913, when George de Hevesy was studying the diffusion of lead into lead, he was inventing a radioisotope diagnostic technique (although he didn't know it at the time). Should a diagnostic method be considered a kind of cure for cancer? Even a surgeon usually doesn't take out a tumor until it has been diagnosed first. Hence, the diagnosis is an essential part of the therapy. The word "cure" encompasses both. If diagnostic methods are included, then an enormous number of "cures" are in process. After all, more radioisotope tests than appendectomies are already being performed in the United States hospitals using radioisotopes. It takes only a state license and a little skill to do an appendectomy. It takes a federal license, a bale of paper, and much skill with a fountain pen to do a radioisotope test.

Turning aside from the purely diagnostic methods (since they are a controversial part of a cure) we will consider only palliative or therapeutic radioisotope methods.

Radioisotopes

The uses of sealed sources of radioisotopes in teletherapy and brachytherapy devices, as far as the cure of cancer is concerned, are really nothing more than an extension of the older radiotherapy ideas. Kilocurie and hectocurie teletherapy units are new only in that there wasn't this much radium available at

the end of the First World War. Almost every brachytherapy idea that has been suggested for radioisotopes was originally tried with radium before 1910. There have been tremendous improvements in teletherapy during the past 10 years, but these were improvements in economics, engineering, and physics. Improvements have been steady in the application of radiation beams to patients, but these are improvements in education. They were not due to any fundamental advance in cancer biology. A few of the brachytherapy ideas, for example implantation of radioactive pellets around the pituitary gland, are really new ideas.

The direct injection of chemically innocuous (but radiation lethal) substances into tumors, or the direct application to surface tumors with radioactive paint should be very useful but has been disappointing. Some of the disappointment rests with the newspaper demands for universality. Some of the disappointment rests in the federal government's demand for 100 per cent safety. Some rests in the lack of availability of materials. However, most of the disappointment probably rests in the fact that these are not automatic methods. Considerable surgical or radiotherapeutic skill is needed to apply the radioactivity. The direct injection of the prostate is a urological feat. Gold-198 is short-lived, and procurement is a problem. Phosphorus-32 raises a chemistry problem. Strontium is tainted with communist fallout and there is a political problem.

Eye applicators have been well developed in England. The direct injection of brain tumors has been tried. Injection of radioisotopes into end artery systems was suggested many years ago, but I believe has not been tried. The use of an artificial heart type of preparation in an artificially closed arterial system is an obvious invitation to radioisotope cancer therapy. The use of colloidal suspensions for the treatment of excessive fluid is only palliative, but this too has its usefulness even though it doesn't "cure." The direct injection of lymphatics has received much investigation in animals; it might be useful in some metastases. Some of the rare-earth isotopes will be picked up and transported through lymphatic channels. Even if it can't be a curative, it might be a preventative method of therapy. The postoperative prevention of iatrogenic seeding is potentially useful, but it can be studied only statistically over a long period of time.

The most obvious (and newsworthy) application of radioisotopes has been the direct metabolic placement of the radiation by the cancer itself. If a tumor of the thyroid gland picks up iodine, it will pick up radioiodine. If it picks up radioiodine, it can be made to irradiate itself to death. This is close to ideal therapy, but it doesn't always work and is restricted to thyroid tissue. Considerable animal work indicates that potassium has an enormous though evanescent uptake in some rapidly growing tumors. There are periodic reports of sulfur having a high differential uptake in some tumors. Always there is the danger of uptake in areas outside of the tumor. At least 276 radioisotopes are of potential medical importance. None are without risks, but then even the simplest surgery has some risks attached.

An almost infinite number of chemical compounds could be made radioactive. Some of these might have a therapeutic usefulness. I know of no theoretical way of predetermining which idea or compound will be successful. I do know that most of these ideas will be unsuccessful. All you can do is try the idea, hoping for success but expecting failure.

Why aren't these ideas being tried? Could it be that the AEC has made radioisotopes unavailable? Could it be that the Poor Food and Drug Act has stifled new therapy? Could it be that the welfare state demands 100 per cent success or no research at all? No, it can't be. This can't happen here.

Route 4, Box 203
Tucson, Arizona

Care Beyond Hospitalization Needed for Addict Patients

The drug addict, even one who enters a hospital voluntarily for treatment, needs care after he is discharged. In most cases, hospitalization is not enough since it cannot protect against relapses. A study of a group of 1881 patients confirms this conclusion. About 90 per cent of the group became readdicted, most of them within six months after discharge from the hospital. No improvement in readdiction rates was gained through hospitalization in excess of 30 days, however. The study opens up new areas for research and for health services through the kinds and amounts of aftercare available to these patients.—G. H. Hunt, M.D., and M. E. Odoroff, M.A.: Followup Study of Narcotic Drug Addicts After Hospitalization. *Public Health Reports.*

Radiographic Examination of the Breast

John N. Wolfe, M.D.
Richard S. McCaughey, M.D.
Ann M. Lewicki, M.D.
Bernard S. Kalayjian, M.D.
Detroit, Michigan

RADIOGRAPHIC examination of the breast or mammography is becoming a popular method of diagnosis in breast disease. There have been periods of considerable interest in this subject in the past, however the procedure has never become a standard radiographic one with routine utilization. With newer techniques and fine-grain x-ray film the study will probably find general use in the differential diagnosis of breast disease and perhaps as a screening procedure for cancer detection in women without apparent abnormalities of the breast.

Salomen,[9] in 1913, made the first radiographs of the breast and described clearly the accurate gross morphology of breast tumors and differentiated between the scirrhous or infiltrating type from the nodular or circumscribed forms of malignancies. Warren and Frey,[2] in 1930 published several papers on mammography and added the technique of stereoscopic radiographs to the investigations. Leborgne,[8] described tumor calcifications which are a peculiar sand-like deposit in or in the vicinity of a malignant breast tumor and are very specific. Gros and Sigrist,[6] of France have written extensively on the subject and outlined well the technique and distinguishing radiographic features of various diseases. Gershon-Cohen and Ingelby,[4] have been enthusiastic supporters of the subject and have correlated excellently the radiographic and pathologic anatomy of the various mastopathies.

Despite these previous evaluations the examination was not used generally, and then, frequently for special reasons as at the Curie Foundation, Paris, where it is used for tumor localization prior to needle biopsy. Egan,[1] in 1960, gave renewed interest to the subject with the report of 1000 mammograms done and their analysis (Table I). His 97 per cent correct identification of carcinomas is an arresting figure; and in addition to this he discovered several occult carcinomas, either in the breast opposite to that under primary attention or in other areas of the same breast. His series comprised 564 patients in all and the incidence of carcinoma was 55 per cent. An investigation of this x-ray examination was begun at the Yates Memorial Clinic and Woman's Hospital, Detroit, Michigan in 1960 and the first 2000 mammograms, comprising 1060 patients were tabulated as a study group. There were three categories:

TABLE I. ANALYSIS OF MAMMOGRAMS

	Wolfe, et al	Egan
Biopsies	572	427
Malignant	17%	55%
Benign	83%	45%
Correct Malign	95%	97%
Correct Benign	85%	91%

1. Yates Memorial Clinic: 320. This is a cancer detection center operated by the Michigan Cancer

Doctor Wolfe is Radiologist, Woman's Hospital, Clinical Instructor Radiology, Wayne State University, Detroit, Michigan.

Doctor McCaughey is Medical Director, Yates Memorial Clinic, Assistant Professor Medicine, Wayne State University, Detroit, Michigan.

Doctor Lewicki is Resident, Radiology, Wayne State University, Detroit, Michigan.

Doctor Kalayjian is Chief Radiologist, Woman's Hospital, Instructor Radiology, Wayne State University, Detroit, Michigan.

Supported by grants from the Michigan Cancer Foundation and Woman's Hospital Research Fund.

Presented in part at the 10th International Congress of Radiology, Montreal, Quebec, Canada, 1962.

Foundation. All women examined and found to have abnormal breasts were submitted to the study without exception.

2. Woman's Hospital pre-operative groups: 360. All women scheduled for breast surgery were radiographed routinely. The cases are consecutive except those patients admitted to the hospital on Sunday and operated early Monday morning. They are therefore unselected and constitute approximately 96 per cent of the total cases biopsied in this institution.

3. Woman's Hospital out-patient group: 380. This comprises referral cases from private physicians and the clinic for evaluation.

An analysis of this series of 1060 patients and those of Egan can be seen in Table I. It is immediately apparent the material differs greatly in the two studies. The 17 per cent incidence of malignant disease seen in the Yates Clinic-Woman's Hospital group is comparable to what one would expect in a general practice. The 55 per cent incidence of malignant disease in Egan's work is consistent with the type of hospital from which the material is drawn; the M.D. Anderson Tumor Institute. The results of the studies are comparable.

Technique

Films are exposed in two projections, a cephalo-caudad and lateral or medial-tangential. In the first, the patient sits on a stool facing a Mayo stand which is adjusted so as to elevate the breast slightly keeping the nipple in profile. The breast is supported on the flat surface of the stand and a film is placed under it. The x-ray beam is directed over the patient's shoulder and includes the retro-mammary tissues. A flat-sided cone is most useful for this. The arm on the side being examined should rest comfortably at the side or on the lap. Included on the film made will be the breast, anterior axillary fold, retromammary fat and varying amount of pectoral muscles. The stand should be of metal so as to absorb all stray irradiation; however, lacking this, one need place only a thin sheet of lead under the film to accomplish this (Fig. 1).

In the lateral or medial-tangential projection, the patient lies on the side to be examined very slightly obliqued. The dependent arm is fully abducted. The opposite hand retracts the opposite breast out of the field. The film is placed so as to include all of the breast and axilla to insure inclusion of the tail of the breast (Fig. 2).



Fig. 1. *(above)* Cephalo-caudad projection: Note that the nipple is in profile and the film is tight against the chest wall. The patient is made very comfortable and her head may rest slightly against the cone.

Fig. 2. *(below)* Lateral projection: Note well the film is under the axilla as well as the breast. The cone covers the tail of the breast as well as the breast itself.

The technical factors are an x-ray beam of very low kilovoltage and high milliampere seconds (Table II).

TABLE II. TECHNICAL FACTORS

Distance	26" — 30"
Kilovoltage	26 — 30
MAS	1500
Filtration	None added
Film	Kodak type M and type AA
Focal Spot	2 mm.

Although a range of kilovoltage from 26 to 30 is shown, practically 95 per cent of patients are filmed at about 26-27, and usually the lateral film requires 1 kilovolt over the cephalo-caudad.

Double loading of industrial film and a medical non-screen film is used and this has certain very important advantages. The industrial type film has an extremely fine grain and will give excellent detail to the main breast mass enabling one to identify readily the very small tumor calcifications and slight areas of invasion around the masses. The type AA film, exposed with the same factors and simultaneously with the type M, gives a tremendous advantage in obtaining an over-exposed film of the breast mass for a more complete evaluation plus a proper exposure of the structures deep against the chest wall, the tail of the breast, and axilla. This obviates the use of a special axillary projection and permits less exposure to the patient and less time for filming by the technician.

When the films are viewed, it is usually helpful to use a low power magnifying glass to scan the films for small deposits of calcification which would indicate a malignant tumor. These frequently are so small and faint as to be seen only by this method.

Normal Mammogram

The normal mammogram is composed of the radiographic image of the skin, pores, areola, nipple, ducts, subcutaneous tissues, fat, veins, arteries, retromammary fat, muscles of the anterior chest wall, connective tissues within the breast and the occasional small three or four millimeter lymph node in the axilla. All of these structures are identifiable and usually distinct.

The various types of normal mammograms correspond to the hormonal status or history of the patient. Thus, in the young adolescent, the gland is extremely dense and compact as contrasted to the involuted gland in the post-menopausal period which is composed mainly of fat. As would be suspected, the latter lends itself to radiographic examination better than the active hormonal stimulated one as the fat lends contrast much as air within the lungs lends contrast.

We distinguish five categories of radiographic development:

1. *Adolescent.*—The parenchyma fills the breast capsule nearly completely. It is homogeneous, the subcutaneous tissues are smooth, sharp and narrow.

2. *Mature.*—As the woman becomes a little older, there is considerable regression of the parenchyma so that it eventually occupies only 30 to 35 per cent of the breast capsule and it becomes roughly triangular occupying the central portion. Fatty tissue fills the periphery.

3. *Parous.*—When the patient has had children, the appearance changes completely to one of a trabeculation with hexagonal or polygomal strands of duct tissue disposed throughout the breast with fat interspersed. This pattern is generalized but most prominent in the upper outer quadrant.

4. *Lactation.*—After pregnancy and the onset of lactation, the breast parenchyma has hypertrophied tremendously and again fills abundantly all of the breast capsule and multiple dilated ducts can be identified coursing toward the nipple.

5. *Atrophy.*—As hormonal stimulation diminishes, there is regression of the duct tissue and increased replacement of volume by fat. This is somewhat selective, as the last area to be replaced is the upper axillary quadrant. This progresses until there is practically no identifiable duct structure.

Benign Diseases

An attempt to discuss completely the entire range of benign diseases of the breast with clinical and pathological correlation will not be made. The reader is referred to some of the excellent work done on this subject by Gershon-Cohen and Ingelby. This topic is concerned mainly with the common aspects of mammary dysplasia, or the various mazoplasias if you prefer. In considering the mammogram several distinct patterns of benign diseases of the breast become apparent, and one can usually distinguish the various types. This must be done with the consideration that benign mammary dysplasia rarely exists in only a single type and the pathologist usually can find evidence of several varieties in the same biopsy specimen, although frequently one is more pronounced. There is often a dominant pattern on the mammogram with lesser degrees of other abnormalities and on this basis we classify them in two major divisions, generalized and localized.

The generalized dysplasias fall into four large categories:

1. *Mammary Dysplasia: Fibrous.*—This is a relatively uncommon type of condition occurring in women during the pre-menopausal period and the mammogram resembles somewhat that of the adolescent female in that there is a paucity of fat, the



Fig. 3. A typical scirrhous type carcinoma. The finger-like infiltrations are on the periphery of the main tumor mass and clearly seen.



Fig. 4. A circumscribed mass. The inferior margin is indistinct. On close inspection small calcifications are noted in the inferior aspect of the tumor.



Fig. 5. On the left a diffuse carcinoma can be seen in the central portion of the breast a little toward the upper quadrant aspect. Its margins are indistinct. On the right a lymph node can be seen demonstrated in the lower axilla against the chest wall by the over-exposed type AA film.

parenchyma fills the breast capsule nearly completely, the subcutaneous fat is only a very thin line and the breast has a nearly even homogeneous appearance.

2. *Mammary Dysplasia: Cystic.*—This is usually in the menopausal and pre-menopausal periods. The appearance is characterized by bilateral masses of varying sizes, irregular ovoid or teardrop deposits of fat throughout and frequently a marked increase in the density of the upper quadrants of the breast.

3. *Mammary Dysplasia: Adenosis.*—This is a more subtle change in radiograph and is characterized by ill-defined patches of increased density frequently approaching a near-spiculated or sun-burst appearance although not often confused with malignancy as there is no accompanying mass. These are usually found deep within the breast and more common in the upper quadrants.

4. *Mammary Dysplasia: Fibrous Atrophy.*—This is seen in the menopausal or post-menopausal patient and is characterized by a prominent increase in the dense connective tissue along the course of the ducts due to atrophy of the ducts with subsequent desmoplasia.

Localized features of the dysplasias frequently are multiple and a classification of them is of some use in the interpretation of the films. There are several types readily identifiable. The more commonly observed include:

1. *Fibro-adenoma.*—This is a tumor mass with a very characteristic radiographic feature. It is usually ovoid or slightly lobulated. If the fat of the breast is sufficient in quantity, it may be compressed, producing a radiolucent halo. These tumors frequently contain calcium deposits of irregular form and size.

2. *Papilloma and Papillomatosis* (Intra-ductal Hyperplasia).—This condition is frequently marked by a distinct tumor mass usually in or close by the sub-areolar area, associated with single or multiple dilated ducts. There are often one or more small flecks of calcific density within the mass. In some cases, one may see only multiple, round, widely separated pin-point deposits of calcification in the sub-areolar area with dilated or confluent ducts.

3. *Duct Ectasia.*—There are many dilated tortuous ducts in the sub-areolar area extending into the parenchyma for short distances and as the disease becomes more advanced there is confluence of the ducts which may contain widely separated distinct rod-like calcifications one or two millimeters in length. Uncommonly, one may see a mass-like accumulation

of ducts deep within the parenchyma of the breast, usually in the axillary upper quadrant and completely separated on the radiograph from any duct ectasia that may occur in the sub-areolar area. These too

1. *Spiculated.*—A mass demonstrating invasion by a spiculated or sun-burst effect around the periphery. This may be a very prominent finding in which case the diagnosis will be extremely accurate (Fig. 3).

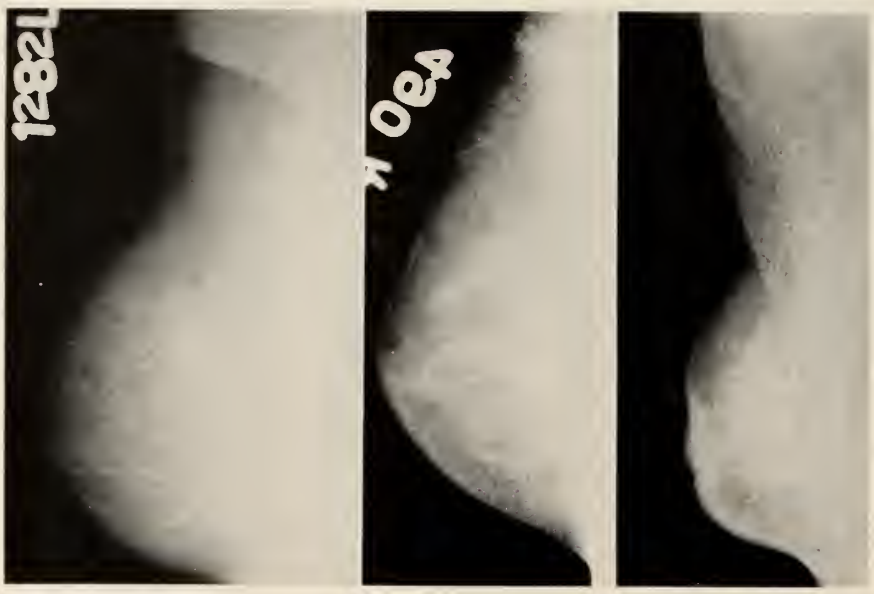


Fig. 6. *(left)* In the tail of the breast, rather high, is a small mass, 5 millimeters. On close inspection multiple, very fine, calcifications can be seen in the adjacent breast tissue over an area of approximately 3 centimeters.

Fig. 7. *(right)* Here are two examples of inflammatory changes from carcinoma. On the left there is minimal thickening of the skin in the intra-areolar area and a mass is not identified within the breast parenchyma. On the right is a more advanced change with marked thickening of the skin, retraction of the nipple and a mass occupying the central portion of the breast.

may contain the rod-like calcifications. We have encountered this in four breasts and the configuration so simulated a mass, we were suspicious of malignancy in the first two. These have produced an abnormality of three to six centimeters in diameter.

Miscellaneous benign diseases of the breast one encounters frequently include abscess, galactocoele, hematoma, and others. Inflammatory conditions of the breast, areola and skin are frequently confused with neoplasm.

Malignant Diseases

The vast majority of malignancies seen are adenocarcinomas arising from the ducts. On the radiograph, one cannot make differentiation comparable to the nomenclature employed by the pathologist, such as comedo, mucoid, carcinoma simplex, et cetera. The radiologist can recognize three morphologic types as a rule and these are:

2. *Circumscribed.*—A mass in which the contour is nodular. There may or may not be demonstrable areas of spiculation also (Fig. 4).

3. *Diffuse.*—A mass lesion, not confined as in one or two, but indistinct in its margins, dense and irregular (Fig. 5).

Secondary signs of malignancy when present can be very specific and are most valuable.

1. *Tumor-Calcifications.*—This is a peculiar sand-like deposit of calcification usually within or adjacent to a mass. The finding is sufficient even in the absence of a mass to warrant the diagnosis of malignancy (Fig. 6).

2. *Skin Edema.*—This is a manifestation of obstruction of the skin lymphatics by tumor cells producing edema of the skin which in its severe form

represents the so-called "inflammatory" carcinoma, and, although usually accompanied by a mass, is sufficient in itself for the diagnosis of carcinoma. It frequently is very limited in its extent, so much so as to escape detection by physical examination (Fig. 7).

3. *Obliteration of the Retromammary Fat Line.*— The normal fat between the breast and anterior chest wall is seen on the radiograph as a dark line of radiolucency one or two millimeters wide. A carcinoma may obliterate this line although this is seldom encountered.

Unilateral increased vascularity has been described as a sign of malignancy. This has not been too reliable in our series as we have observed breasts with malignant tumors having normal, increased and decreased blood supply and many normal dysplastic breasts with increased vascularity.

Discussion

Radiography of the breast appears to afford an accurate evaluation of breast disease. It is an examination that is quickly and easily done with no discomfort to the patient. It has several objectives:

1. It is designed primarily as an aid in assessing the type of disease process within the breast. It is not intended primarily to diminish the number of biopsies done; however, it would seem if the clinical impression is that the disease is benign and the radiologist's opinion is a firm one of benign disease, the private physician may be sufficiently reinforced and elect not to biopsy at that time. The radiographic interpretation is a consultation and, as Table I clearly demonstrates, is often enough incorrect.

2. The radiographs serve as a permanent record in the follow-up examinations on patients with multinodular breasts. It is difficult to construct a visual image of multiple masses within the breast for follow-up purposes, whereas a permanent accurate record is afforded by the radiograph and can be readily compared with subsequent periodic films either on a routine basis or when a change is suspected by the private physician on physical examination. This is especially useful in those patients who have already had numerous breast biopsies.

3. X-ray examinations of patients with multiple breast masses may direct attention to a malignancy which is masked by overlying benign tumors.

4. Mammograms will occasionally discover a completely occult cancer. This has occurred approximately fifteen times in our experience. Most commonly, it has been in the breast opposite to that under study. There have been instances where the patient has presented with positive axillary lymph nodes and no palpable breast mass; and less commonly in women with completely normal breasts; the mammograms being done as a routine. This occurrence of occult breast cancers will probably result in the routine use of the procedure in normal women in the age group most likely to have breast cancer, and in women who have had one breast cancer, or in patients in whom members of the immediate family have had breast cancer. These two latter groups are more likely to develop carcinoma of the breast.

Summary

A statistical analysis of radiography of the breast for the detection of carcinoma has been presented. The technique is that of a low kilovoltage, high milliampere seconds x-ray beam and the use of a high quality x-ray film. Films are exposed in two projections, medial lateral and cephalo-caudad. A classification of benign diseases of the breast is divided thus:

1. Generalized
 - (a) Mammary dysplasia, fibrous
 - (b) Mammary dysplasia, cystic
 - (c) Mammary dysplasia, adenosis
 - (d) Mammary dysplasia, fibrous atrophy
2. Localized
 - (a) Fibro-adenoma
 - (b) Papilloma, papillomatosis
 - (c) Intraductal hyperplasia
 - (d) Duct ectasia
 - (e) Miscellaneous

Malignant diseases were divided into three morphologic types:

1. Spiculated
2. Nodular
3. Diffuse

Secondary signs of malignancy were:

1. Tumor calcification
2. Skin edema
3. Obliteration of the retromammary fat
4. Unilateral increased vascularity

A discussion of the uses of mammography in practice was presented.

Triple Biopsy in Carcinoma of the Breast

C. S. Kennedy, M.D.
E. B. Miller, M.D.
D. C. McLean, M.D.
Detroit, Michigan

CARCINOMA of the breast is too broad a subject about which to think without confining one's thoughts to similar stages of the disease. We use the Columbia Clinical Classification devised by Haagensen and Cooley[1] in order to secure the limitation and definition necessary for rational presentation. It is based on certain signs of inoperability for hope of cure and certain grave signs published by Haagensen and Stout;[2] and, is represented in Table I. The great value of the Columbia Clinical Classification is that it is based entirely on findings before the institution of any treatment, and thus the opportunity is afforded to avoid operations which have no hope of curing the patient. The results at The Grace Hospital for 557 cases of carcinoma of the breast, each classified according to the Columbia method, are presented in Table II.

The figures from The Grace Hospital are especially interesting in that they compare equivalent stages of carcinoma of the breast treated by different means:

1. Simple mastectomy followed by x-ray therapy of the order of 1,000 R total.
2. Less than three-hour radical mastectomy following the Mayo Clinic or European technique.
3. Three-hour or more radical mastectomy adhering more closely to Halsted's principles.

However, this comparison has been reported previously;[3] and the point to be made at this time is that judgments of curability based on the Columbia Clinical Classification as it existed in 1956 were not satisfactory regardless of means of treatment although it offered the best criteria then available. Haagensen realized the need for a more accurate means of determining choice of treatment pretherapeutically, first, because radical mastectomy in inoperable patients may well shorten life, as illustrated in Table III,[4] and second, because operation is not the only nor even the best means of treating some carcinomas of the breast previously considered operable. This latter fact has been well illustrated by Guttmann's work.[5] Certainly we do not want to do a mutilating operation in the hope that it may do the patient some good if we can determine before the operation that it offers no hope of cure. Even more certainly we do not want

TABLE I. COLUMBIA CLINICAL CLASSIFICATION

Clinical Group	Clinical Features
A	1. No clinically involved lymph nodes. 2. No grave signs.
B	1. Clinically involved nodes (trans. diam. less than 2.5 cm.) 2. No grave signs.
C	Any one of the following five grave signs: 1. Limited skin edema (involvement less than ⅓ skin over breast). 2. Ulceration of skin. 3. Solid fixation primary tumor to chest wall. 4. Axillary nodes 2.5 cm. or greater in diameter. 5. Fixation of axillary nodes to skin or surrounding tissues.
D	Any one of the following ten conditions: 1. Any two or more of above five grave signs. 2. Edema involving ⅓ or more of skin over breast. 3. Satellite nodules in skin over breast. 4. Inflammatory carcinoma. 5. Parasternal tumor nodules. 6. Edema of the arm. 7. Distant metastases. 8. Microscopically proved supraclavicular metastases. 9. Microscopically proved apical axillary metastases.* 10. Microscopically proved internal mammary metastases.*

*Criteria applied by Haagensen only since 1956 and at The Grace Hospital since 1958.



Author

C. S. KENNEDY, M.D.

From the Division of Surgery, The Grace Hospital, Detroit, Michigan and the Wayne State University College of Medicine, Detroit, Michigan.

to do a procedure that will shorten the lives of our patients.

If the above reasoning applies to the type of Halsted radical mastectomy done by Haagensen,[1] it applies equally or more so to the Mayo, or "standard" or European type of radical mastectomy. The Grace Hospital figures in Table II show a better survival with axillary metastases for simple mastectomy than for the less than three-hour radical mastectomies. This advantage of simple mastectomy has been pointed out previously in comparing Kennedy's cases to the Mayo Clinic Series.[6] We suggest that we either follow McWhirter's lead in Scotland and abandon radical mastectomy completely or that we take more time for meticulous radical mastectomies following Halsted's principles and do them only in those patients with a hope of cure.

TABLE II. FIVE-YEAR SURVIVAL RATES THE GRACE HOSPITAL

Columbia Clinical Group	No. of Cases	Five-Year Survival	Percentages
Simple Mastectomy (Kennedy 1927-1956, The Grace Hosp. 1951-1956)			
A	136	86	63%
B	39	16	41%
C	23	6	26%
D	48	7	14%
Total	246	115	47%
Survival less clinically inoperable cases			55%
Less than three-hour radical mastectomy (Grace 1951-1956)			
A	151	97	64%
B	40	10	25%
C	22	8	36%
D	12	0	0%
Total	225	115	51%
Survival less clinically inoperable cases			54%
Three-hour or more radical mastectomy (Grace 1951-1956)			
A	58	45	78%
B	12	9	75%
C	9	6	67%
D	7	2	29%
Total	86	62	72%
Survival less clinically inoperable cases			76%

In Columbia Clinical Group A cases at The Grace Hospital in the last decade, there has been a gradual increase in the number of radical mastectomies taking at least three hours. This increase is illustrated in Table IV which shows that the upward trend is most marked beginning in 1958; however, it is our belief that this trend will not continue if, even with the most favorable cases clinically determined, there is a 22 per cent failure as was shown in Table II. Haagensen realized this not long after 1950;[1] and in the light of this realization and especially in view of the work of Handley,[7,8] devised triple biopsy consisting of: (1) biopsy of the primary tumor, (2) biopsy of the lymph node at the apex of the axillary chain, and (3) biopsy of the internal mammary lymph nodes in the first three intercostal spaces.

TABLE III. DURATION OF LIFE IN BREAST CANCER FROM ONSET TO DEATH
(From C. D. Haagensen)

	1915-1950 Presbyterian Hospital Cases Classified as Inoperable by Clinical Criteria Because of Extent of Local or Regional Disease But Without Distant Metastases		Untreated Cases Collected by Wade From Various Sources
	Treated by Radical Mastectomy	Treated by Irradiation Only	
Number of Cases	124	145	777
Mean Survival (months)	37.8	41.2	38.5

The indications for such a biopsy, in our opinion, are simply as follows:

A. In Columbia Group A tumors.
 (1) If tumor is in a central or medial sector of the breast and at least 3 cm. in diameter.
 (2) If tumor is in a lateral sector and at least 5 cm. in diameter.
B. In all Columbia Group B and C tumors.

Of the deaths at The Grace Hospital in Columbia Group A cases following any kind of radical mastectomy, Table V shows that 34 of 67 (51 per cent) had indications for a triple biopsy. By comparison, the same type of cases that survived for at least five years had only 16 per cent in whom a triple biopsy was indicated. Also of significance is the fact that in the three-hour or greater radical mastectomies very probably with triple biopsy, 77 per cent of the deaths in Columbia Group A could have been foretold; and hence, these useless operations avoided. A

TABLE IV. CHOICE OF TREATMENT IN COLUMBIA CLINICAL CLASSIFICATION GROUP A CASES OF CARCINOMA OF THE BREAST AT THE GRACE HOSPITAL OVER TEN-YEAR PERIOD

Year	Percentage Simple Mastectomy	Percentage Less Than Three-Hour Radical	Percentage Three-Hour or More Radical
1951	20	76	4
1952	40	45	15
1953	12	58	30
1954	42	42	16
1955	25	55	20
1956	30	50	20
1957	38	48	14
1958	30	32	38
1959	22	45	33
1960	20	40	40

much lesser percentage (44 per cent) of correction would be possible in the less than three-hour radical mastectomies since so many of the deaths were due to the shortcomings of the operations themselves.

TABLE V. DEATHS IN COLUMBIA CLINICAL CLASSIFICATION GROUP A CASES AT THE GRACE HOSPITAL 1951 to 1956

	Three-Hour or Greater Radicals	Less Than Three-Hour Radicals
Total number of deaths	13	54
Number in which triple biopsy indicated	10	24
Number of deaths probable if triple biopsy	3	30
Percentage of deaths due to failure of operation	23%	56%

In summary, the above facts constitute a plea for careful physical examination and grouping of cases of carcinoma of the breast according to the Columbia Clinical Classification followed, when indicated, by triple biopsy as described by Haagensen and finally in those cases with a hope of cure followed by the type of radical mastectomy advocated by Halsted, most recently described by Haagensen in his book and which takes him and us about six hours to complete.

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Cites Advantages of Home Care Programs

The plus factors of a good home care program were cited by Sidney E. Chapin, M.D., Dearborn, when he spoke at the annual meeting of the Michigan Dietetic Association.

In his talk, "Bringing the Hospital Home," he declared:

"A good home care program provides a continuity of services between the hospital and the establishment of a comparable regime at home.

"A good home care program gets the patient out of the institutional atmosphere in which he becomes the prisoner of his bed because he has no place to go.

"A good home care program provides the enlivening surroundings of home which are necessary to strengthen the patient's will power to effect a cure.

"A good home care program is a rehabilitative project, aimed at marshalling community resources for physical and psychological retraining of the handicapped.

"A good home care program evaluates the patient in terms of his own potentialities and provides the services required for achieving goals—this being the basis for good rehabilitation. Each patient is considered an individual, regardless of age, and the program is tailored to his individual requirements."

Conservative Management of Colonic Polyps

Based on Roentgenographic Observations of Growth Rate

Leo S. Figiel, M.D.
Steven J. Figiel, M.D.
Fred K. Wietersen, M.D.
Detroit, Michigan

MUCH speculation exists regarding the causal relationship of the colonic polyp and colonic carcinoma. Until recently most authorities believed that the majority of colonic carcinomas probably resulted from malignant change in the benign colonic adenoma or papilloma. Histologic studies provided considerable evidence to support this thesis, since all gradations of malignant change from atypism of the cellular structure to invasion of the muscularis mucosa and metastases to blood vessels and lymph nodes have been reported. However, there are some who believe the so-called "de novo carcinoma" though very rare, occurs with sufficient frequency to explain the incidence rate of colonic carcinoma. Recently, Spratt and Ackerman[16] and Castleman and Krickstein,[3] have expressed the opinion that the adenomatous polyp very likely is a lesion of negligible malignant potential, however, indicate that a villous or papillomatous polyp may undergo malignant change.

There is, however, general agreement that carcinoma of the colon and rectum in its early forms manifests itself usually as a sessile, or less frequently, pedunculated polypoid growth which can be differentiated accurately only by careful histologic study. On this basis, surgical removal of all colonic polyps has been generally recommended. The rule "Every polyp is a potential cancer" has been applied without consideration of such factors as the age of the patient, the size of the polyp, or the surgical risk involved as measured against the risk of carcinogenisis if the polyp remained untreated.

We have advocated radiologic follow-up and conservative management of small colonic polyps since 1956, especially in older or surgical risk patients. We do not believe surgical removal of every polyp beyond the reach of the endoscope is necessary.[10] In fact, experience has taught us that in most cases removal will not be required since the benignancy or malignancy of a polyp can be established without recourse to histologic study by evaluating its growth behaviour on progress or serial barium enema studies.

Our opinions and policies are based on a cumulative experience of over 300 cases in which polyps of varying size detected by roentgenologic methods and located beyond the reach of the endoscope were followed roentgenographically for periods ranging from two to nine years. We have proven that carefully executed roentgenologic follow-up studies will permit a highly accurate differentiation of benign from malignant or potentially malignant polypoid tumors with extreme safety to the patient. A polypoid tumor which does not grow or increase in size can be safely presumed to be benign (Fig. 1). A polypoid tumor increasing in size, especially one which doubles its volume, in the first six to 12 months of observation, must be considered malignant or potentially malignant and should be removed.

Background

Utilization of high kilovoltage techniques at the Grace Hospital since 1953 has resulted in an increased detection of small polyps under 1 cm. in size. A significant increase in the detection of such lesions was noted following the routine use of high KV spot compression radiography which was developed at our hospital in 1956.[8,9]

Practically all polyps discovered during these years (unless contraindications were present) were removed surgically, necessitating in many instances, segmental, subtotal or total colectomy for removal of extremely

Author
LEO S. FIGIEL,
M.D.



From Grace Hospital, Detroit, Michigan.

small lesions which in a vast majority of instances were proven benign.

Fortunately, in 1955, Arminski and McLean[1] at the Grace Hospital, reported that careful microscopic analysis of 647 colonic polyps established a definite correlation between the size of the polyp and malignancy. The incidence of carcinoma in polyps under 1 cm. in size was less than 2 per cent and was 0.2 per cent or less in lesions under 5 mm. in size. Similar findings have been reported by Grinnell and Lane[11] in 1958, and by Spratt and Ackerman[18] in 1960. When the importance of this fact was realized, we felt one could no longer rationalize surgical removal of every colonic polyp without first evaluating the surgical risks involved.

Our opinions regarding roentgenologic follow-up of colonic polyps were strengthened by the high incidence of colonic polyps reported in autopsy material by Arminski,[2] Feyrter[7] and Hultborn,[14] who found polyps in 50 per cent or more of older people. In other words, one out of every two people over the age of 60 harbors one or more colonic polyps. Arminski[2] indicated that in his study of 1000 autopsy cases, this figure applied only to adenomatous and papillomatous polyps and excluded other histologic lesions.

Multiple lesions have been reported in 15 to 50 per cent of patients with colonic polyps further complicating this problem. In his series of 1800 autopsies, Feyrter[7] reported a total of 1017 polyps in 386 cases. Arminski[2] indicated that 46.5 per cent of his autopsy cases had two or more polyps.

Our review of the literature and a study of operative cases at the Grace Hospital indicated the mortality and morbidity associated with the removal of polyps



Fig. 1. Case of a 48-year-old white man operated on in 1954 for polypoid carcinoma of the hepatic flexure. A small pedunculated sigmoid polyp was discovered in 1956. Yearly follow-up studies for five years have showed no change in the size of this polyp. Presumed to be a benign lesion because of absence of growth.

1 cm. or smaller in size, especially if segmental resection was required, presented a greater risk to the patient than the risk of a polyp being or becoming malignant. Spratt and Ackerman,[18] in 1960, drew the same conclusions from a study of their material. They recommended that lesions under 1.2 cms. in size be treated conservatively and observed for changes in size, properly assuming that an increase in size was the earliest indication of a potential cancer. Their recommendation was based on personal material which showed that the mortality attending the surgical removal of the colonic polyp exceeded the risk of the small polyp (1.2 cms. or less) being malignant.

A more widespread realization and appreciation of the data published by Arminski and McLean,[1,2] Collins, et al,[4,5] Feyrter,[7] Helwig,[13] Hultborn,[14,15] Grinnell and Lane,[11] Spratt and Ackerman,[16,17,18,19] Castleman and Krickstein,[3] and others, will undoubtedly result in a complete re-evaluation of currently accepted concepts and conclusions regarding the colonic polyp, its causal relationship to carcinoma, its histopathology and surgical treatment. A more conservative approach will surely result when this data is properly evaluated. In fact, at the present time a strong trend has developed in the American and

European literature advocating conservative management of smaller colonic polyps.[10,18,21]

Growth of Colonic Carcinoma

In recent years, we have collected 18 cases of documented cases of this type correlates accurately with our findings.[5,10,14,19,20]

We have been able to establish growth data correlating volumetric increases in the size of a tumor against specific time intervals, so-called "doubling



Fig. 2. Case of a 60-year-old white man, showing the development of a polypoid carcinoma of the sigmoid in four years. Adenocarcinoma Grade III with metastases to lymph nodes. Small polypoid tumor unrecognized on examination February 20, 1957.

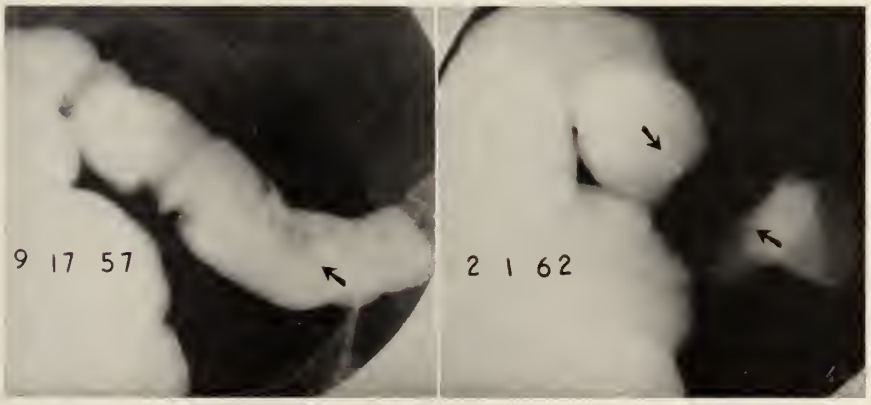


Fig. 3. Case of a 49-year-old white woman, showing the development of an annular carcinoma of the sigmoid in four and one-half years. Pedunculated polypoid tumor reported on barium enema studies of September 17, 1957. This patient was untreated and never returned for additional x-rays until the studies of 1957.

carcinoma of the colon in which we were able to review earlier radiographic studies and unequivocally demonstrate growth in all segments of the colon of the typical advanced carcinoma from polypoid tumors as small as 1 cm. in size. Our studies indicate that the time interval required for a 1 cm. polypoid tumor to develop into the typical polypoid or annular carcinoma varied between two to five years (Figs. 2 and 3). In rare instances, a longer period of time was noted. The majority of carcinomas in our series developed in two to three years. A study of case reports in the literature which include radiographically time"[4,5] which prove that the vast majority of colonic carcinomas grow at a relatively slow and predictable rate. In a number of cases our studies proved that growth of colonic carcinoma progressed in a linear or exponential fashion, i.e., doubling in the volume of a tumor occurred periodically at uniform intervals of time.

These observations indicate that colonic carcinoma grows quite slowly and further suggests that roentgenologic progress studies can be utilized as a means of determining whether a colonic polypoid tumor is benign or malignant, i.e., the malignant polypoid

tumor or early carcinoma will demonstrate growth (doubling in volume) in six to 12 months or less, whereas benign polypoid tumors will generally show no change in size or may grow very slowly on extended observation.

genographically and the advisability of surgery determined on the basis of growth or absence of growth (Fig. 4).

We believe it is probably safer to follow a pedunculated polypoid tumor than a sessile tumor of com-

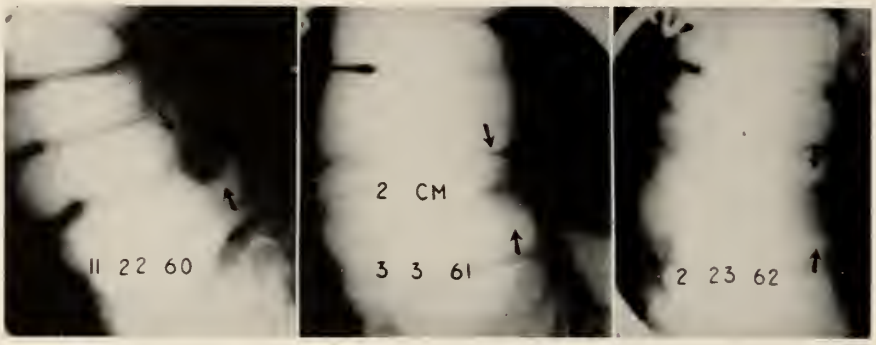


Fig. 4. Case of a 72-year-old white woman who is a cardiac patient. No change was demonstrated in a 2 cm. polypoid tumor of the ascending colon in one and one-quarter years. Conservative management is predicated on the absence of growth—the lesion is presumed to be benign. Yearly follow-up examination is recommended.

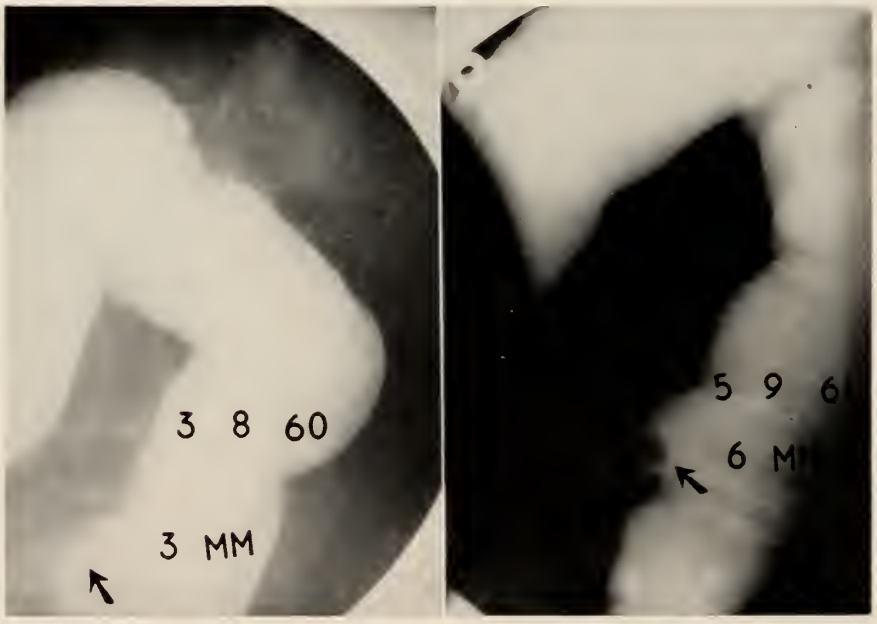


Fig. 5. Case of a 60-year-old white man with a small polypoid tumor in the proximal descending colon which increased from 3 to 6 mm. in size on a follow-up of one year and two months. Because of the rapid growth this lesion was considered potentially malignant and was removed surgically. Histologically, this was proven to be a benign adenomatous polyp.

Radiographic Follow-Up of Colonic Polyps

We are inclined to agree that polypoid tumors larger than 1 cm. in size should be removed, however, in older patients especially those with medical complications larger lesions may be followed roent-

parable size because most authorities agree that there must be invasion of the stalk of a pedunculated polyp before metastasis can occur. The rarity of metastasis to lymph nodes in cases of pedunculated adenomas with carcinoma further supports this opinion.

Roentgenologic follow-up of colonic polyps is a simple procedure. We recommend follow-up studies of patients with polyps measuring 1 cm. or less in size in six months. If no growth occurs during this interval a second examination is performed six months later. If no growth occurs during the initial year of study this indicates the presence of a benign lesion and yearly follow-up observations are carried out.

If a polyp increases in size during the first year of observation, surgical removal should be considered. Doubling in the volume of a polyp in the first six to 12 months or less should suggest a possible malignancy and such polyps should be removed (e.g., a polyp increasing in diameter from 1 cm. to 1.2 cms. has doubled its volume) (Fig. 5.)



Fig. 6. Case of a 70-year-old white man with an eight-year follow-up of a pedunculated polypoid tumor in the descending colon. The patient was operated on because two small polyps were discovered in the sigmoid in 1962. All lesions were removed and were proven benign adenomas on histologic study.

Results

In our series of approximately 300 cases, surgery was recommended in four instances because a rapid growth rate was noted in the first year of observation and potentially malignant tumors were suspected. In all four cases, the tumors were removed and benign adenomas were proven histologically.

Since benign polyps may increase in size, this will continue to be a source of error as we depend on the demonstration of growth as our primary criterion of potential malignancy. To date, we have not encountered a single case in which malignancy was proven in this series of cases.

A number of patients in our series were operated for other reasons and colonic polyps removed after extended roentgenologic observation. Benign tumors were predicted since these lesions remained unchanged in size over two to eight years of observation. These were proven to be benign adenomas or papillomas and, therefore justify our assumption that a polypoid tumor which does not grow or increase in size is benign and need not be removed (Fig. 6).

About 285 cases are being followed and have been spared the risk of surgery because these tumors have shown no growth or insignificant growth on extended observation and are presumed benign. In the event any of the polypoid tumors in this group should show a sudden acceleration or growth and therefore suggest the possibility of malignant transformation, we would recommend surgical removal although we are aware that a rather rapid growth may occur in benign adenomas or papillomas without known cause.

Conclusions

Surgical removal of all colonic polyps beyond the reach of the endoscope is precluded by the high incidence of polyps in older people, and the extremely low incidence of malignancy in colonic polyps smaller than 1 cm. in size.

Roentgenologic follow-up studies permit a highly accurate differentiation of the cancer potential of smaller colonic polyps with practically no risk to the patient. A polypoid tumor which does not grow or increase in size on progress studies can be safely presumed to be benign. A polypoid tumor which increases in size should be considered potentially malignant and should be removed.

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Respiratory Enzyme Activity of Human Gliomas

Following is a digest of paper given at recent meeting of the Detroit Physiological Society by Drs. J. L. Chason, J. W. Landers, J. E. Gonzales and G. Brueckner, all of Wayne State University, Detroit.

Slide methods using MTT and Nitro BT for eight respiratory enzymes have been applied to normal, reactive and neoplastic "glial" cells obtained at operation and/or at autopsy. Two dehydrogenases, B-hydroxybutyrate and alcohol, were not found in any cells of the central nervous system or in their reactive or neoplastic counterparts. Increased respiratory enzyme activity was characteristic of reactive glial cells and of gliomas. The activity of reactive astrocytes and oligodendrocytes was one of a moderate increase in LDH, DPN-D and SDH and mild increase of alpha-GPDH, MDH and isoCDH. The activity of the neoplastic cells was characterized by a marked increase in DPN-D and LDH activity, a moderate increase in SDH and a mild increase in alpha-GPDH, MDH and isoCDH.

These results are in contrast to a few previous reports of decreased respiratory enzyme activity in gliomas.

The Use of Percutaneous Needle Biopsy To Confirm the Diagnosis

Robert F. Johnston, M.D.
Eloise, Michigan

NEEDLE biopsy of lung tumors is a well-described but currently somewhat-neglected diagnostic procedure. In 1940, Carver described experience with 230 aspiration biopsies of lung tumors. In 64 of these cases, material diagnostic of malignancy was obtained.[1] In 1949, Gledhill reported 56 needle aspirations of lung tumors. In 44 patients (78.5 per cent), he was able to make a diagnosis of malignancy from this procedure.[2] Rosemond reported a series of 300 cases of aspiration biopsy of lung tumors. Of 220 cases suspected of having lung cancer, 163 were histologically proven by all methods. In 135 of these, the diagnosis was made by aspiration biopsy.[3] In 1954, Dutra and Geraci reported three cases of bronchogenic carcinoma successfully biopsied under fluoroscopic control with the Vim-Silverman needle.[4] In 1957, Morrison and Deeley reported their experience with drill needle biopsy of intrathoracic lesions. Their instrument was a hollow needle rotated at 20,000 revolutions per minute by a compressed air-driven motor. They obtained satisfactory biopsies in 26 of 32 peripheral lung lesions.[5] Perttala, in 1959, reported 75 lung biopsies in 73 patients using the Silverman-Goldman needle. In 19 (38 per cent), the diagnosis of cancer was definitely established and in 15 (30 per cent) more, material suspicious of cancer was obtained.[6] Miller, in 1960, using the Vim-Silverman needle, reported 10 consecutive cases of clinically malignant, nonresectable pulmonary tumors in which needle biopsy was used. In all 10, the diagnosis of malignancy was established by needle biopsy.[7]

The series reported suggests that needle biopsy of intrathoracic tumors can be a valuable diagnostic procedure. In our hospital population, the incidence of bronchogenic carcinoma is high. Pathologic confirmation of this diagnosis can usually be obtained by cytologic examination of the sputum, bronchoscopic biopsy, scalene-node biopsy, biopsy of a metastatic lesion, or thoracotomy.[8] However, there are a small number of cases where despite strong clinical evidence of lung cancer, confirmatory pathologic material cannot be obtained. *In the patients with clinical evidence of nonresectability or whose general condition will not permit thoracotomy, needle biopsy of the tumor or the metastatic lesion has been very helpful.* Although treatment available for patients who have nonresectable pulmonary neoplasms is unsatisfactory, tissue is needed to confirm the diagnosis. Then, palliative treatment can rationally be advised and prognosis can be estimated. In a 15 months' period, six patients were subjected to needle biopsy, and in all the diagnosis of malignancy was established.

Technique

We have limited biopsy of intrapulmonary lesions to those that exhibit evidence of chest-wall invasion by a palpable mass or rib destruction on the chest roentgenogram. With the larger chest masses, the site for biopsy can usually be accurately located by study of posterior-anterior and lateral chest films. The region to be biopsied is located on the film in relation to bony landmarks, e.g., ribs, spinous process of the vertebra, the top of the scapula, or the lateral border of the sternum, and the appropriate measurements are transferred to the patient. The lateral film is helpful in determining the depth from the skin of the lesion. Occasionally, oblique views and laminograms have been utilized to determine the location of the lesion more exactly.

In attempting to biopsy smaller lesions or aspirate ribs, it has been helpful to place a lead marker at the proposed site. A roentgenogram is then taken and by relating the marker to the lesion, the exact site for biopsy can be readily located. Fluoroscopy with

From the Medical Service, Veterans Administration Hospital and The Department of Medicine, University of Michigan Medical Center, Ann Arbor, Michigan.

Doctor Johnston's present address: Department of Medicine, Wayne County General Hospital, Eloise, Michigan.

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direct marking of the skin serves the same purpose. Fluoroscopy has not been used during biopsy.

In all cases, tumor masses in the lung have been sampled using the Franklin modification of the Vim-Silverman needle. Standard percutaneous biopsy technique is used,[9] although with this needle it is not necessary to rotate the biopsy needle before withdrawal. The core of tissue obtained is placed immediately in 10 per cent formalin. In sampling bony lesions, an 18-gauge bone marrow needle with a stylet is used. Forceful aspiration with a 20 or 30 cc. syringe is applied after the needle is imbedded in the marrow. From the material obtained, cover-slip preparations are made immediately, and these are subsequently prepared with Wright's stain. The residual clot is fixed in 10 per cent formalin, dehydrated with alcohol, cleared with xylol and imbedded in paraffin. Serial sections are then prepared which are stained with hematoxylin and eosin.

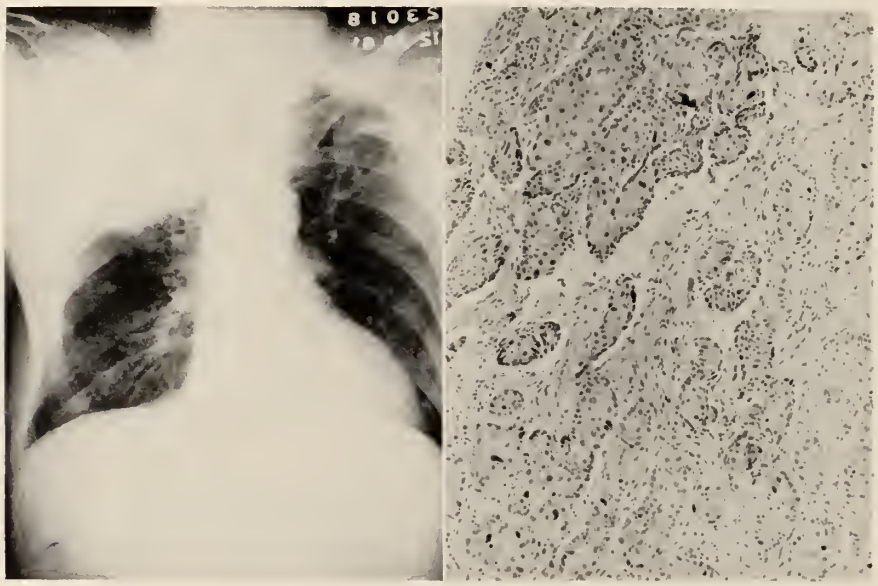


Fig. 1. (a) Right upper lobe mass with metastatic disease in right middle and lower lung fields. (b) Well-differentiated squamous cell carcinoma obtained by needle biopsy of right upper lobe mass. Hematoxylin and eosin stain x 20.

Case Reports

Needle Biopsy of Lung Tumors

Case 1. (D.C. AA, VAH No. A-8693).—This 74-year-old white man had right shoulder pain for 11 months. He had had a chronic cough and smoked heavily for many years. There had been weight loss of 45 pounds in the last year. Five months before admission, the diagnosis of lymphosarcoma involving the lung had been made elsewhere. At that time, his white blood count was 250,000 with 97 per cent lymphocytes. He was treated with a brief course of radiation therapy to the right lung, triethylene melamine and steroids. However, right shoulder and chest pain persisted.

Examination on admission showed a pale, confused, elderly white man. The significant physical findings included dullness and absent breath sounds over the right upper lobe posteriorly. Just medial to the right scapula, a slight bulge in the chest wall was noted which measured 6 x 7 cm. The liver was moderately enlarged, but the spleen was not palpable. Many small lymph nodes were felt.

Laboratory examination showed a white count of 64,100 with 36 per cent segmented neutrophils, 2 per cent bands, 51 per cent large lymphocytes, and 11 per cent small lymphocytes. The platelets were normal. The hemoglobin was 12.3 gms. The hematocrit was 41.5 per cent. Bone marrow showed 10 to 12 per cent small lymphocytes, decreased megacaryocytes, erythroid hyperplasia, and was interpreted as consistent with chronic lymphocytic leukemia. One sputum cytology was negative; one was suspicious for malignant cells.

Chest roentgenograms showed a large mass in the apex of the right lung with rib destruction. A small nodule was present in the right lower lung field, and parenchymal abnormality was noted in the left upper lobe (Fig. 1a). The clinical diagnoses were chronic lymphocytic leukemia and bronchogenic carcinoma. Biopsy of the large lung mass was done with a Vim-Silverman needle. The specimen showed fibro-adipose tissue infiltrated with squamous cell carcinoma (Fig. 1b). There were no complications from the biopsy procedure.

The patient received chemotherapy in the Veterans Administration Co-operative Study of Lung Cancer. However, his condition deteriorated steadily, and he died six weeks later. Postmortem examination showed carcinoma of the right upper lobe with chest-wall invasion and metastases

to the right lower lobe, adrenal glands, hilar lymph nodes, liver and kidneys.

Case 2. (R.F. AA, VAH No. A-9072).—This 68-year-old white man was admitted to the hospital because of pain in the anterolateral aspect of the right chest and in the right scapula of three months' duration. Twelve years before, the diagnosis of pulmonary embolus and infarction of the right upper lobe had been made. Five years before, the diagnosis of minimal pulmonary tuberculosis of the right upper lobe had been made but not confirmed, and he was begun on antituberculous chemotherapy which was continued for three years. His roentgenograms over this interim showed stable parenchymal and pleural scarring at the right apex. A tuberculin test was positive. Four years before admission, he had minor hemoptysis. At that time, bronchoscopy and sputum cytologies were negative. He had smoked at least one pack of cigarettes a day for 40 years.

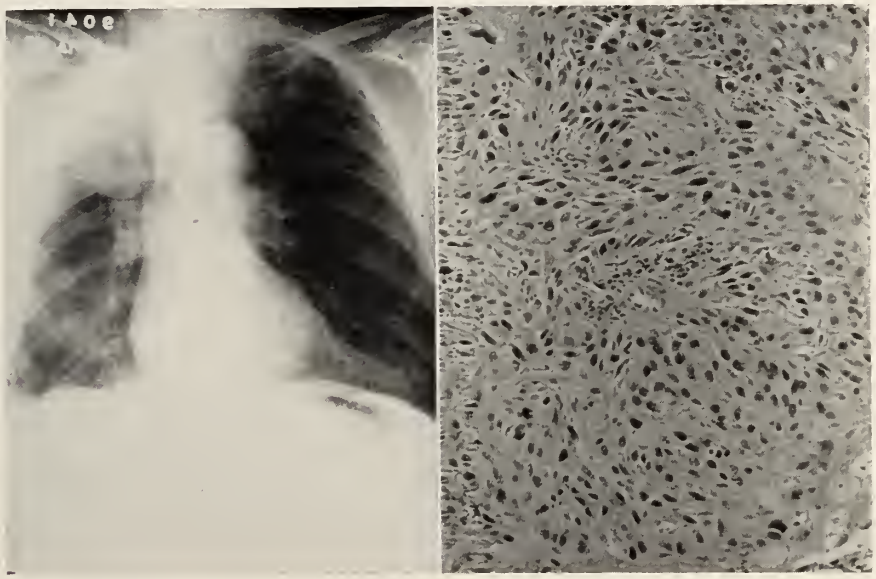


Fig. 2. (a) Right upper lobe mass. Noted destruction of right posterior 5th and 6th ribs. (b) Squamous cell carcinoma obtained by needle biopsy of right upper lobe mass. Hematoxylin and eosin stain x 40.

Significant physical findings on admission were deviation of the trachea to the right, questionable fullness medial to the right scapula, and dullness and decreased breath sounds at the apex of the right lung. Chest roentgenograms (Fig. 2a) showed a large mass at the apex of the right lung destroying the 3rd and 4th posterior ribs.

Sputum smears were negative for acid-fast bacilli. One sputum cytology was suspicious for malignant cells.

The first two attempts at needle biopsy of the lung mass yielded only chronic inflammatory tissue. However, the third biopsy yielded poorly-differentiated squamous cell carcinoma (Fig. 2b). Following the positive biopsy report, malignant cells were found in the sputum. The patient was refused for operation because of chest-wall invasion, and entered the Veterans Administration Cooperative Study of Lung Cancer. He died three months later after developing transverse myelitis and penumonia. There was no necropsy.

Case 3. (W.C. AA, VAH No. A-7484).—This 61-year-old white man had pain in the right shoulder, arm and hand for 13 months prior to admission. Diagnoses had included root compression by osteoarthritis for which cervical laminectomy had been performed without benefit. When muscle atrophy appeared in the right shoulder and arm, the diagnosis of possible amyotrophic lateral sclerosis had been made. Lung cancer was not suspected until chest films 13 months after the onset of pain showed destruction of the right 3rd rib (Fig. 3a). In retrospect, the chest roentgenogram had been abnormal for nine months.

Nine sputum cytologies were negative for malignant cells. Three were unsatisfactory. Right scalene-node biopsy was negative. Needle biopsy of the apical lung mass was attempted, but no tumor tissue was obtained. The second biopsy obtained poorly-differentiated carcinoma in fibrous tissue (Fig. 3b).

The patient was treated with radiation therapy in an attempt to palliate the severe right arm and shoulder. He died two months after biopsy, and necropsy was not performed. It became clear, in retrospect, that all his neurological symptoms may have been due to tumor which clearly was present nine months before his final admission.

Needle Biopsy of Metastatic Lesions

Case 4. (E.M. AA, VAH No. A-3607).—This 60-year-old white man gave a long history of increasing dyspnea accompanied by wheezing and cough. Ten months before, he was treated for congestive heart failure, and at that time the chest roentgenogram and the electrocardiogram showed evidence of right ventricular hypertrophy. During that hospital admission, he developed pneumonia in the left lower lobe. Bronchoscopy was negative. He returned to the hospital with increasing dyspnea and left chest pain.

Examination showed cyanosis and marked dependent edema. The trachea was shifted to the left, and there was flatness to percussion over the lower one-half of the left chest with absent breath sounds. He was cachetic, and there was no clubbing. The electrocardiogram showed incomplete right bundle-branch block and right ventricular hypertrophy. Sputum culture grew out coagulase-positive staphylococci. Hemoglobin was 15.2 gms. and hematocrit, 51 per cent. White count was 14,400. Acid-fast sputum cultures were negative.

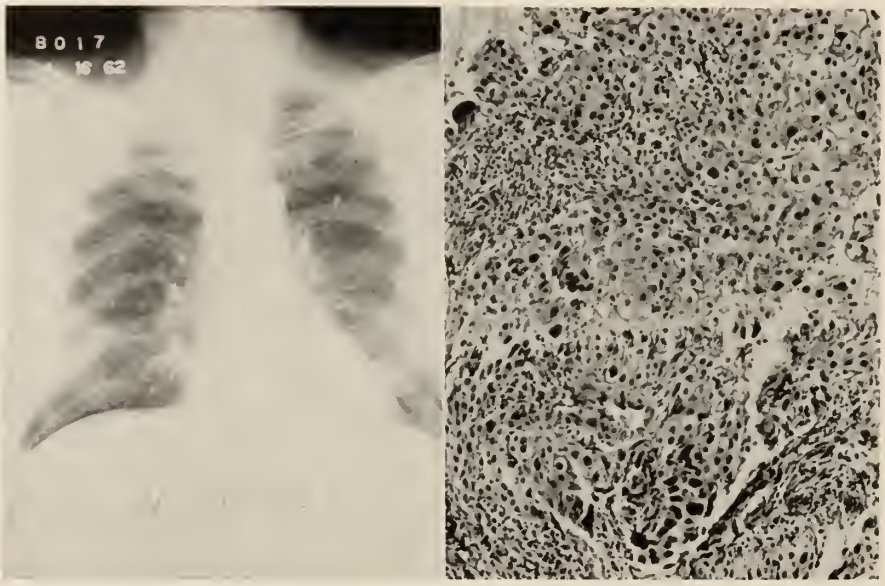


Fig. 3. (a) Large peripheral mass, right upper lung field, and smaller mass at right base. (b) Poorly differentiated carcinoma obtained by needle biopsy of right upper lobe mass. Mucicarmine stain x 40.

Initial chest roentgenogram showed complete opacification of the left chest, which may have been pulmonary edema as he lay continuously on his left side. There was gradual clearing of the left chest as his congestive heart failure was treated. On a follow-up film, excavation was noted in the superior segment of the left lower lobe. The next chest film showed a destructive lesion in the left 6th posterior rib. After a film had been obtained with a marker, the 6th rib was aspirated; and, in the sections prepared from the clot, undifferentiated carcinoma cells were found. Prior to the rib aspiration, six sputums obtained for cytologic examination were unsatisfactory, and one was reported as negative for malignant cells. During the hospitalization 10 months before, three sputums were unsatisfactory for cytologic examination. The diagnosis of carcinoma was confirmed at necropsy three months later.

Case 5. (C.J. AA, VAH No. A-6517).—This 62-year-old white male noted increasing cough, sputum, and left chest pain 2 months before admission. Studies done prior to admission included a chest roentgenogram showing infiltrative disease in the left upper lobe, a negative bronchoscopic examination, and bronchial washings which contained no malignant cells.

Examination showed decreased breath sounds over the left upper lobe anteriorly. There was no definite dullness. There were bilateral wheezes, and there was tenderness over the chest cage. The abdomen was distended, and the ankle and knee reflexes were absent. White count was 20,000. Hemoglobin was 10.3 gms.

Chest film showed a left hilar mass with infiltrate in the left upper lobe. There was a right paratracheal mass and lytic lesions in the right 4th posterior rib, the right lateral 10th rib, and the left 3rd rib with an associated pleural mass (Fig. 4a).

Four sputums were unsatisfactory for cytologic examination. The right 4th rib was aspirated, and many malignant cells were found both in the hematologic and pathologic preparations (Fig. 4b).

The patient's condition deteriorated rapidly with development of a transverse myelitis followed by death. No postmortem examination was obtained.

Case 6. (L.A. AA, VAH No. A-7463).—This 74-year-old white man was admitted to the hospital because of left shoulder pain. Four months before admission, the patient had developed a cough productive of white sputum and noted moderate dyspnea on exertion. Five weeks before admission, he began to note pain in the left shoulder which was accentuated by activity and became gradually worse. His chest roentgenogram one year before showed no abnormalities.

Examination showed bilateral basilar rales and wheezing in the right chest. There was tenderness over the 2nd and 3rd thoracic vertebrae, and tenderness over the upper scapula and the acromial process on the left. Adduction of the left arm was painful, and fasciculations were noted in the left arm muscles. Muscular power was decreased in the left upper extremity. There was no sensory loss, and the re-

flexes in the left arm were normal. No Horner's syndrome was present. The remainder of the examination was normal except for splenomegaly.

Tuberculin test was positive; histoplasmin test, negative. Chest films revealed an infiltrative lesion located in the lingula of the left upper lobe. Films of the left shoulder showed a lytic lesion in the left scapula just medial to the glenoid fossa (Fig. 5a).

Sixteen sputums were negative for malignant cells; seven were unsatisfactory. After obtaining a film with a lead marker to accurately localize the scapular lesion, needle biopsy was performed. The material obtained was reported as poorly-differentiated adenocarcinoma (Fig. 5b).

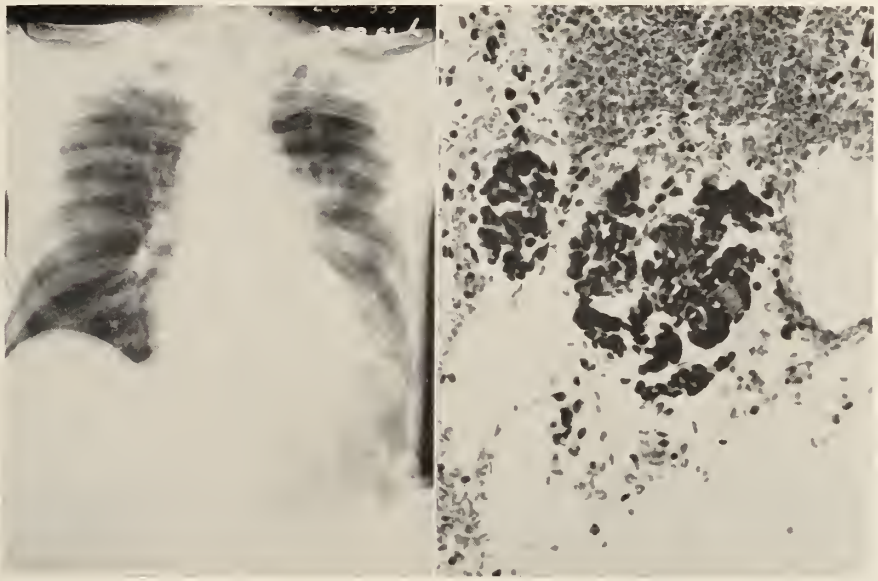


Fig. 4. (a) Left hilar and right paratracheal masses. Note the destructive lesion in the right posterior 4th rib located just below the lead marker. (b) Aspirate obtained from right posterior 4th rib, containing blood and large deeply-staining malignant cells. Hematoxylin and eosin stain x 80.

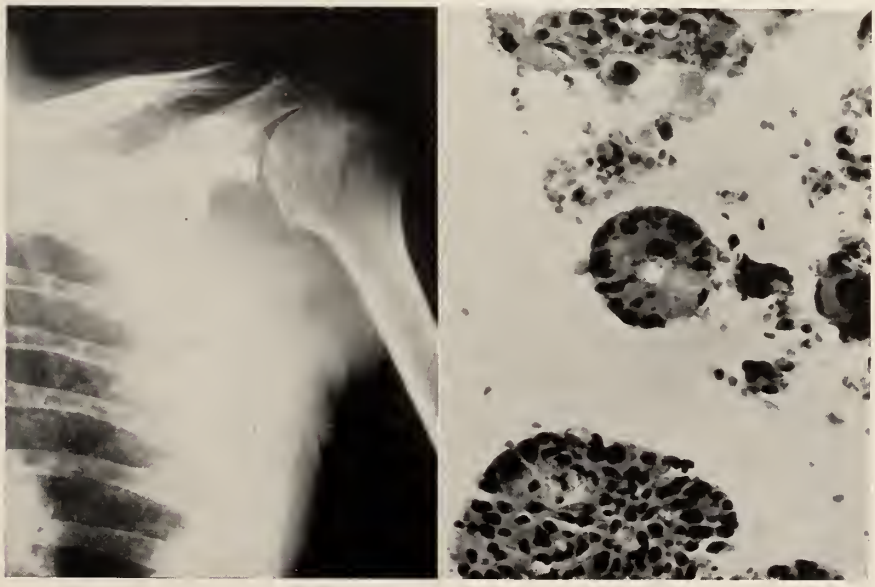


Fig. 5. (a) Left shoulder showing large destructive lesion in glenoid area of scapula (just below marker). Note "pneumonic" appearing pulmonary lesion at the bottom of the film. (b) Poorly differentiated adenocarcinoma obtained by needle biopsy of left scapula lesion. Hematoxylin and eosin stain x 80.

The patient received radiation therapy to the scapular lesion with some temporary pain relief. However, his condition progressively deteriorated, and he died with the clinical

picture of disseminated neoplasia 9 months after admission. Postmortem examination showed that the lung lesion, indeed, was adenocarcinoma. There were metastases to the liver, kidneys and the left scapula.

Comments

In five of the six patients, the only pathologic confirmation of tumor during life was obtained by needle biopsy. In Case 2, after the diagnosis had been confirmed by positive needle biopsy, malignant cells were found in the sputum. In Cases 3 and 5, the only tissue proof of cancer was obtained by needle biopsy.

Discussion

In our experience, needle biopsy of the lung and metastatic tumors has been a helpful diagnostic tool. The technique is simple, and the equipment readily available in most hospitals. The per cent of positive results should be very high, for the areas to be biopsied can be accurately located by the roentgenogram. The procedure causes very little patient discomfort and can easily be repeated if the first attempt is unsatisfactory.

We have not biopsied pulmonary tumors where there has been aerated lung between the tumor mass and the chest wall. We have sampled only those tumors where there has been evidence of chest-wall invasion. This obviously reduces the risk of pneumothorax and probably, also, the risk of bleeding and air embolism. However, the many reported biopsies of lung tumors not invading chest wall suggests that this, too, is a relatively safe procedure. In a review of the English literature, three fatalities closely following needle biopsy of the lung have been found. These were all reported by Rosemond in a series of 300 needle aspirations of the lung.[3] One death was due to tension pneumothorax in a patient who also had severe emphysema, another was attributed to air embolism, and the third was from a myocardial infarction which occurred 24 hours after the biopsy. In Rosemond's series, the mortality was 1 per cent. However, in a total of 406 biopsies of lung tumors in the other series cited, there have been no mortalities.[1,2,4-7]

The commonest complications have been small pneumothorax and minor hemoptysis. Carver reported nonfatal episodes in two patients which may have been due to air embolism.[1] Other complications that have been reported include one empyema,[6] one case of severe pneumonia,[6] and fever and chills following shortly after biopsy.[3,6]

The possibility of tumor growing along the needle tract or of tumor cells being implanted in the needle tract has been used as an objection to needle biopsy of lung tumors.[7,10] Dutra and Geraci found a subcutaneous mass at the biopsy site three months after needle biopsy of a lung tumor had been performed. Excision showed this to be neoplastic. Burnett, as quoted by Miller, reports that microscopic evidence of tumor in serial sections of the needle tract was found in one patient who had been subjected to needle biopsy of a lung tumor.[7] These are the only two instances of implanted carcinoma in the large number of biopsies reviewed. As needle biopsy is advocated only in those patients who have evidence of nonresectability, the slight possibility of tumor implantation along the needle tract is not an important criticism of the procedure.

Summary

The technique of needle biopsy of lung and metastatic sites to confirm the diagnosis of lung cancer has been described. The use of this technique to establish a tissue diagnosis in those patients who have evidence of nonresectability or who cannot withstand thoracotomy is advocated. The procedure has been demonstrated to be safe, simple, and highly accurate in properly selected patients.

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Early Detection of Nasopharyngeal Cancer

Robert D. Burton, M.D.
Grand Rapids, Michigan

IT IS the common belief that a "lump in the neck" is an early sign of cancer in the nasopharynx. In reality however, this glandular symptom indicates widespread dissemination of the primary nasopharyngeal tumor.[1] When the tumor has metastasized to the neck nodes, the survival rate falls accordingly. In a recent study Vaeth[2] observed a five-year survival of 52 per cent in those patients in whom the lesion was limited to the soft tissue of the nasopharynx. This fell to 26 per cent when the diagnosis was made after the lesion had metastasized to unilateral cervical lymph nodes.

The examining physician must be aware of earlier signs of nasopharyngeal cancer if the prognosis is to be changed for the better. It is becoming apparent that disturbances of the ear are often the first clues to the cancer in the nasopharynx. These disturbances include (1) unilateral hearing loss, (2) tinnitus and (3) intermittent sharp stabbing pain in the ear. These were the initial complaints present in over half of the cases reported by Maddox in 1960.[3] Therefore it behooves the examining physician to be more "cancer-conscious" in this area of the body. It is a sad fact that the average interval between the onset of symptoms and the actual diagnosis is ten to eleven months.[4] The cause for some of this delay must be accepted by the medical profession. The length of this delay in diagnosis is in part due to the lack of recognition by the physician of certain early signs and for this reason most observers feel this delay can be shortened in the future if these early signs are looked for.

Pathology

The diagnosis of the cell type composing the tumor may vary from pathologist to pathologist, due to the anaplastic nature of the tumor. They are usually classified as epidermoid carcinomas, transitional cell carcinomas (Fig. 1) or lymphoepitheliomas. The cell type is often difficult to classify and for this reason the incidence of various types differ greatly in case reports. The Chinese diagnose most of these as lymphoepithelioma and it is stated that 70 to 80 per cent of nasopharyngeal tumors seen in Chinese are of this type.[5] In England, Lederman[6] reports that in his cases, over 60 per cent are of the epidermoid carcinoma type while the incidence in a series by Eberhard and Leaming[7] list 40 per cent as epidermoid carcinoma and 10 per cent lymphoepithelioma.

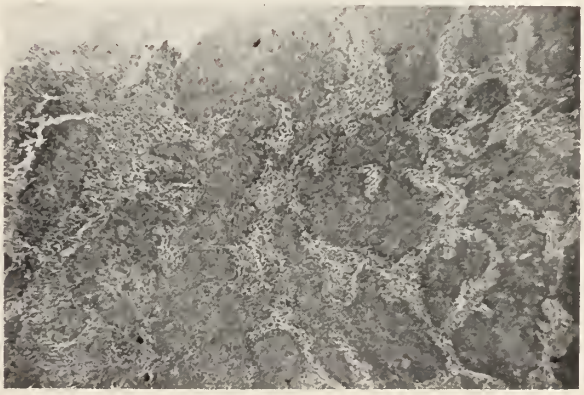


Fig. 1. Transitional cell carcinoma, showing the syncytial nature of the tissue and lack of keratin formation.

Diagnosis

As was stated earlier, otologic findings are often the first indication of the disease. Hearing loss, tinnitus, and intermittent pain are manifestations of serous otitis media. This middle ear disturbance is caused by interference with the normal function of the Eustachian tube.

The Author

ROBERT D. BURTON

M.D.



Upon examining the ear the observer notes a retracted amber-colored drum with a thin "chalky" appearance of the malleus handle. A conductive-type hearing loss of 20 to 30 decibels is responsible for the complaint of deafness and tinnitus. The intermittent sharp pain is also a result of middle ear effusion.

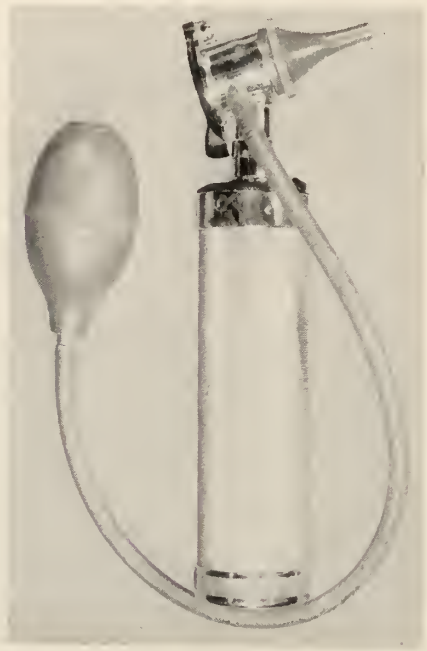


Fig. 2. A pneumatoscope for determining the presence of fluid in the middle ear.

The diagnosis of this effusion is aided by use of a pneumatoscope. To convert an ordinary otoscope to a pneumatoscope all that is needed is a diagnostic otoscope head, a No. 20 Fr. rubber catheter, and an atomizer bulb (Fig. 2). A normal drum will move to and fro as the bulb is squeezed and released, while a drum with fluid behind it will remain rigid.

Lack of grasping the possible seriousness of the situation leads into delay of treatment with a wait-and-see approach. It also may lead to "masking therapy" such as repeated myringotomies, insertion of polyethylene tubing or frequent inflation of the Eustachian tubes.

The nasopharynx must be carefully examined if the above signs and symptoms are present. Only in this manner will earlier diagnosis of this disease be made. This examination usually is successful by proper use of the nasopharyngeal mirror with or without local anesthesia. A nasopharyngoscope also is a valuable aid but is less helpful in searching the lateral angles of the nasopharynx. Occasionally, a "blind" biopsy and examination under general anesthesia succeeds where other diagnostic procedures have failed.

Later signs and symptoms indicate spread of the neoplasm from the confines of the nasopharynx into nearby tissues and consequently result in a less favorable response to treatment. The metastatic spread to cervical lymph nodes should alert the examiner to view the nasopharynx before proceeding with a node biopsy. As in all neoplasms, the first attention should be locating the primary rather than dealing with metastatic lymph glands.

Metastatic spread to nearby nerves causes symptoms of visual disturbances, ocular paralysis, facial pain, unilateral headache and trismus. This invasion of the cranial nerve foramina and fissures is common as the disease progresses. Nasal symptoms of obstruction and unexplained bouts of epistaxis frequently occur in the course of the disease and usually indicate a well differentiated lesion of epidermoid carcinoma type. Eventually, x-ray changes occur, resulting in erosion of the skull best seen on basal skull views.

Case Presentations

Case 1.—A 38-year-old man was seen first in June, 1961. Originally, he was evaluated at a surgical out-patient department and referred the same day for ear evaluation. He complained of progessive hearing loss over 4-5 months and recently an aching sensation in the neck. Examination showed a retracted right drum with fluid in the middle ear. Enlarged lymph nodes also were palpated in both cervical chains. A nasopharyngeal biopsy was performed and reported as lymphoepithelioma of the nasopharynx. Cobalt irradiation was given with good response by the primary and also the metastatic nodes. At present he shows no evidence of primary tumor in the nasopharynx.

Comment.—This patient waited for four to five months before seeking medical help. During that time, the primary had spread to homolateral and contralateral nodes with consequent lowering of the favorable long term response.

Case 2.—A 45-year-old man was seen first in March, 1962, with a history of having five myringotomies, low intensity irradiation to the Eustachian tubes, and anti-histaminic therapy over a six-month period for persistent serous otitis media. Examination in March showed a large bulky tumor in the nasopharynx occupying both fossae of Rosenmuller which when biopsied several days later was reported as transitional carcinoma of the nasopharynx. There were no enlarged nodes present in the neck. External irradiation

therapy has resulted in total visible disappearance of the tumor with return of hearing in both ears.

Comment.—The original examiner must have realized that the source of trouble was in the region of the Eustachian tube orifice in light of the myringotomies and small doses of irradiation to the nasopharynx. A malignancy apparently was not considered, however.

Case 3.—A 57-year-old man was seen in May, 1961, having had complaints of rather rapid loss of hearing in the right ear with associated epistaxis for the past eight months. The epistaxis was controlled by his doctor by means of anterior nasal packing and a recommendation of a hearing aid made to correct his hearing loss. He was first seen for epistaxis which on a following examination proved to be related to a mid-line nasopharyngeal mass. There were no palpable lymph nodes present in the neck. The nasopharyngeal mass was biopsied and reported as transitional cell carcinoma of the nasopharynx. Cobalt irradiation has resulted in return of hearing in the right ear but a recent repeat biopsy has shown recurrent carcinoma in the primary area.

Comment.—The symptom of hearing loss along with nasal bleeding makes the nasopharynx an area of high suspicion. Any conductive type hearing loss coming on this rapidly warrants a more thorough otologic evaluation including audiometric studies.

Case 4.—A 72-year-old man was first seen in October, 1961, with a complaint of popping and gurgling in the left ear. On initial examination, a serous otitis media was noted and also a deformity of the torus of the left Eustachian tube. The fluid was cleared from the middle ear with ease by inflation of the Eustachian tube but recurred on several occasions. Although no lesion was seen, a "blind" biopsy was taken from the left fossa of Rosenmuller under general anesthesia and was reported as transitional cell carcinoma of the nasopharynx. An enlarged cervical node and the nasopharynx were treated by external irradiation with no present visible evidence of primary malignancy.

Comment.—This man came to the physician early in the disease and in spite of careful examination on several occasions only did a "blind" biopsy prove the true cause of this otologic complaint. It is sometimes astounding to find a vast degree of secondary symptoms arising from spread of a very small primary.

Treatment

Most of the nasopharyngeal lesions are radiosensitive and melt away rapidly under radiation therapy. In most instances, a cancerocidal dose is given by external irradiation with intracavitary irradiation reserved for recurrences and later metastatic spread.[8] The method of delivering the irradiation is determined by the therapist with the otolaryngologist following the size of the lesion and condition of the treated area at selected intervals during and following the course of therapy. To aid in observation of the nasopharynx Pang[9] advocates palatal fenestration. This is an aid in directly viewing the area to perform "spot" biopsies of questionable tissue and also may be an aid in using intracavitary irradiation.

Summary

Carcinoma of the nasopharynx is a highly malignant disease. Certain otologic signs are often present in the early phase of the disease which should alert the examining physician to the possibility of a lesion lurking in the nasopharynx. Treatment can then be begun earlier with a more favorable over-all response to therapy.

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Michigan's 3000 Candidates For Practical Cancer

M. J. Brennan, M.D.
Detroit, Michigan

IN 1963, about 7,500 persons will die of cancer in Michigan. Of this number, 1,100 will suffer with lesions which have arisen in the colon or rectum, 850 in the breast, 450 in the prostate, 220 in the lymph nodes or bone marrow, 100 in the corpus uterus, and 200 in the ovaries.

Consequently, 2,920 persons will have died of neoplasms which are properly the subject of systemic chemotherapy or hormonal treatment. It is unlikely that more than 1,000 of these patients will have come under the direct management of physicians specializing in the care of disseminated cancer. Of these 1,000, about 400 will have received significant benefit from the agents and techniques now available.

This benefit will have consisted of relief of severe pain for some weeks or months, a gain in weight, restoration of appetite and energy, a clearing of mental depression, and a return in large or small part to their habitual activities. One half of this number (200), in addition to the symptomatic improvements listed above, will have experienced a clear-cut decrease in size or even a disappearance of observable tumor metastases, a correction of anemia, a notable increase in strength, and relief of severe physiologic defects of respiration, locomotion or gastrointestinal function. For these 200, "objective regression" of disseminated cancer will have been achieved. This improvement will have lasted anywhere from three to 15 months for 190 of them. The remaining 10 will have stayed well somewhat longer, one or two having been restored to health for several years.



The Author

M. J. BRENNAN, M.D.

Potentially, the total group of 3000 patients who will die in Michigan in 1963 of chemotherapeutically vulnerable neoplasms contains at least 700 persons who might have experienced very satisfactory, though temporary, improvements in the state of their health had it been possible to extend to the whole group the maximal benefits which can be afforded by present-day medicine.

For the 2000 or so persons who share homes with these unfortunate patients, and for the additional 25,000 or more tied closely to them by bonds of friendship and relationship, the respite which can be gained by a remission of six or eight months in the disease process would certainly have been something of value.

Some physicians, noting that improvement, even though dramatic, usually lasts only a few weeks or months, feel that all these treatments accomplish is a delay or interruption of decline without change in the essential shape of the course with time. Therefore, they fear that patients and families are put to increased expense without adequate reason when systemic therapy is attempted for disseminated cancer.

Observations made over a span of 10 years during the treatment of some 2,000 patients with disseminated cancer underlie the following opinions:

1. Intensive chemotherapy does not add notably to the cost of caring for patients with disseminated cancer. It functions as a replacement of other medical expenditures, not as an additional one. Few hospitalizations are needed for chemotherapy alone. The disease itself leads to the hospitalization, which is in some cases notably shortened by successful treatment and rarely prolonged by unsuccessful treatment.

Doctor Brennan is Physician-in-Charge, Division of Oncology, Henry Ford Hospital, Detroit, Michigan.

2. Patients responding to systemic therapy with objective regression of disease live longer by three to six months than those who fail to respond. The mean prolongation of life produced by a given agent is related closely to the mean duration of objective regression induced by that agent. The additional time lived is valuable on a humanitarian scale of values. It does not consist of a mere prolongation of biological survival in some deprived status of existence.

3. At least one-fifth of persons with chemically vulnerable neoplasms experience objective regressions of disease after appropriate treatment. Another one-fifth experience an arrest of the disease and a major amelioration of symptoms, even though objective evidence of decrease in tumor mass cannot be developed. For many of these, evidence of return to more physiological levels of organ function, hematopoiesis, protein metabolism, and work tolerance can be obtained even though decrease in tumor mass is not demonstrable. For most agents, one may expect at least as many improvements of this sort as of the "objective" kind. "Objective regression" in the American literature today is a technical term. It is applied by chemotherapists only to instances of regression to 50 per cent, or less, of pretreatment size in at least 50 per cent of all demonstrable lesions without increase in even one of multiple lesions. Patients not manifesting this very marked kind of response are scored "failures" for technical reasons. But all patients who are *scored* failure are by no means therapeutic failures to the clinician as opposed to the investigative chemotherapist. Granted a therapeutic trial "objective regression" rate of 15 per cent for five fluorouracil in the treatment of colon carcinoma, one can expect a 30 per cent rate of worthwhile clinical results in a properly treated group of non-terminal patients.

4. The patients who are treated chemotherapeutically for disseminated cancer and who fail to show a clinical improvement from this treatment probably have their lives shortened by the treatment. As a result, in a very large series, where survival curves for patients managed without chemotherapy for lymphoma have been compared to others managed with it, the over-all survival of the two groups has not been notably different. Since successfully treated cases are known to live longer than those who fail therapy, however, and since their survival as a group is better than that of the non-chemotherapeutically treated population, it follows that those not helped by treatment were, to some extent, made worse by it. Here again, chemotherapy is seen to prolong life only insofar as it improves it.

PRESENT CHEMOTHERAPEUTIC RESULTS IN DISSEMINATED SOLID TUMORS

TYPE	AGENTS	INDICATIONS AND RESULTS
Breast	5-Fluorouracil Cytoxan	Progression of disease in spite of hormonal treatment or ablative surgery. 25 per cent objective regressions; mean duration, 4.5 months.
Prostate	Cytoxan	Disease refractory to castration and estrogens. 10 per cent objective regressions; 5 months duration.
Corpus Uterus	Cytoxan	15 per cent objective regressions; 6 months duration.
	Progesterone	25 per cent objective regressions; 6 months duration.
Ovary	Cytoxan 5-Fluorouracil	15 per cent objective regressions; 4 months duration.
	Radiogold and Radiophosphorous colloid	45 per cent pleural and peritoneal effusions controlled for 4 months.
Colon and rectum	5-Fluorouracil	15 per cent objective regressions; mean duration. 6 months.

Hormonal therapy of breast and prostate cancer yields 25 per cent objective regressions in the former and 45 per cent in the latter. Chemotherapy of leukemia and lymphoma is effective in at least one half of the cases. Duration of objective regressions averages eight months in these categories.

Miscellaneous tumors which respond to various special agents are thyroid cancer, myeloma, choriocarcinoma of pregnancy, carcinoma of the testis, Wilm's tumor and neuroblastoma of children, and carcinoid tumor.

5. The loyalty, generosity, and friendship which the families of patients who have died on our service have manifested towards us and our work and the interest and support which they have, in many cases, shown towards it over a number of years, lead us to believe that even in instances where no improvement has been gained following treatment, those closest to the patient have thought the effort worth-while. This could not be true were chemotherapy so costly in a humanitarian sense as many of its detractors claim.

6. Treatment which is corrective only for a short time is not useless. Men generally understand, even when physicians have failed to do so, that the function of practical medicine is not so much to give life as to ameliorate it. No one in his right mind really expects us to give immortality, though all expect us to give help. Our people are not inclined to expect a great deal from us, and therefore are seldom dismayed by our failures. Temporary improvements are less than we, or they, would prefer. But here, as elsewhere in this earthly life, half a loaf is better than none. Indeed, for most of us in middle life, it can be an unexpected and eminently satisfactory prize.

Conclusions

Cancer chemotherapy, even with the crude, weak, toxic, and only fractionally effective methods which we have today, has a practical role in medicine. There will appear in Michigan this year, 2,950 likely candidates for treatment with the drugs now available on the general market. Since only about 1,000 of them will be seen by men specializing in this work, it is necessary, if 2,000 people are to obtain the very real help open to them, that physicians generally do their best to learn to utilize these drugs in a prudent and effective way.

A table is included to indicate the kinds of neoplastic disease we have found responsive to chemotherapeutic and hormonal treatment, the agents we are now using in each of them, and an estimate drawn from published work and our own experience of the frequency with which one may expect a reasonably beneficial response to occur.

Careful adjustment of regimen to the individual case is critical for drugs with a narrow therapeutic range. The proper use of chemotherapeutic agents is an art which can be achieved through long hard experience or, with less time and anxiety, through tutelage. At first, it is best for a man attempting to do this work to associate himself in some way with someone who has been practicing it. This can be done through thoughtful participation in the management of a series of one's patients with a consultant, while at the same time developing a knowledge of the literature on the agents concerned.

Experienced chemotherapists are to be found associated with many hospitals in the state of Michigan. A considerably larger cadré needs to be developed, however. It is hoped that this estimate of the dimensions of the medical service we ought to provide in cancer chemotherapy, together with some clarification of its nature and purpose, will encourage additional physicians to interest themselves actively in the subject.

Harper Hospital Plans Centennial, May 1-2-3

Harper Hospital will celebrate its Centennial in Detroit on May 1-2-3.

The first official Centennial activity was a "Junior Medical Press Conference" for 300 student journalists from the Detroit schools on March 13 at the hospitals. Eugene A. Osius, M.D., Chief of Staff, presented a historical sketch of medicine, as well as an actual patient.

The climax of the Harper Celebration will be a two-day Centennial Symposium, May 2 and 3, on "Medicine and Genetics." Specialists will present technical papers to the more than 1,500 alumni of Harper Hospital gathered for the event. The speakers will include Drs. Earl Green of the Roscoe B. Jackson Clinic of Maine, Earl Sutton of the University of Texas, and Barton Childs of Johns Hopkins University.

Another featured event will be a Civic Centennial Banquet, May 3, at Cobo Hall in honor of Harper Hospital's historic celebration. The principal speaker will be T. Stewart Hamilton, M.D., President of the American Hospital Association and director of the Hartford Hospital.

Members of the General Centennial Committee include Mrs. Muriel Pearse, R.N., Mrs. Harold Mack, Eugene A. Osius, M.D., George Cartmill, with Messrs. Glancy and Hudson. Sub-committee chairmen include Harold B. Fenech, M.D., Harold C. Mack, M.D., Edgar E. Martmer, M.D., Mrs. Harriet Bell, R.N., Mrs. Barbara Johnson, Miss Gwen Cruzat, William Peacock, Charles Hagler, and Andrew Barr.

Harper Hospital was incorporated on May 4, 1863 by the Michigan State Legislature. The first hospital buildings were erected in 1864 as a general hospital for the care of Civil War wounded.

Problems of Early Diagnosis In Bronchogenic Carcinoma

Charles M. Norris, M.D.
Philadelphia, Pennsylvania

THE PROBLEM of early diagnosis of carcinoma of the bronchus has many important aspects. Only 40 years ago, the number of cases of bronchogenic carcinoma in which the diagnosis was proven or even suspected during life was extremely small. Along with the recent remarkable increase in the apparent incidence of this disease, adequate facilities for diagnostic study have become more available, and the proportion of the cases proven during life has shown a progressive increase. In spite of this fact, the incidence of operability and resectability remains rather low. In the experience of Chevalier Jackson Bronchoscopic Clinic, approximately 52 per cent of the patients have been found to have clinical evidence of inoperability when referred for examination, and in the remaining 48 per cent, where operation was performed, resection could be performed in only 39 per cent, so that the overall incidence of resectability was found to be 18 per cent.

It has been found that the average interval between the onset of symptoms and the first visit to the patient's physician is about three months, and that in the average case, a second interval of between three and four months elapses before the first x-ray examination is made. Following this, in the average case, a third interval of more than five months has elapsed before the diagnosis is proven. Most cases of carcinoma of the bronchus will pass from an operable to an inoperable stage within this period of nearly a year.

Let us consider the reasons why diagnosis in the average case is so long delayed. Unfortunately for both the patient and his physician, the early symptoms of carcinoma of the bronchus are the same as those of a wide variety of pulmonary diseases, most of which are not disabling or of serious nature. This is particularly true of cough, the most common early symptom, which is usually considered in the initial phase to be a manifestation of some unimportant chronic inflammatory disease. The second most common early symptom, hemoptysis or blood-streaking, is more likely to be recognized as calling for further investigation. The importance of wheezing as an early symptom is often not recognized, even after the patient has seen his doctor, and many patients have been treated under an inferential diagnosis of "asthma" without realization of the need for roentgen and bronchoscopic examinations.

Frequently, medical advice is not sought until the occurrence of those complications which depend on bronchial obstruction. It has been found that more than half of the patients seen in the bronchoscopic clinic for the first time gave a history of having had acute febrile illnesses suggestive of one of the common lower respiratory infections, but probably related to the occurrence of bronchial obstruction. These patients have been treated under such diagnoses as lobar pneumonia, bronchopneumonia, unresolved pneumonia, virus pneumonia, pleurisy, influenza, acute bronchitis, and so forth. It is quite apparent that no case of so-called "pneumonia" should be dismissed as cured until a negative chest x-ray can be demonstrated; and persistence of chest symptoms or signs following what has appeared to be a mild respiratory infection, should always call for roentgen examination and probably bronchoscopy.

So far as the physician is concerned, the solution of the problem of early diagnosis depends on recognition of the indications for roentgen examination and bronchoscopy. In this connection, it should be emphasized that negative x-ray findings do not exclude the need for bronchoscopy in the presence of hemoptysis, wheezing or unexplained cough. Many delays in diagnosis have occurred because the physician, reassured by negative x-ray findings, has deferred bronchoscopy until the occurrence of such complica-

The Author
CHARLES M. NORRIS, M.D.



tions as atelectasis, pulmonary abscess or empyema. In the same way, it may be said that the presence of abnormal physical findings, audible with the stethoscope, such as wheezing, localized rales, or impaired aeration, should require bronchoscopy even though the x-ray be negative.

The early manifestations of a bronchial carcinoma, depend to a large extent on the point of origin, so that an arbitrary classification based on location is of more practical value for clinical consideration than one based on gross or microscopic characteristics of the tumor itself. Therefore, let us consider separately those tumors which arise in a main or lobar bronchus, those which arise in a segmental bronchus, and those which arise peripherally.

It is believed that somewhat more than 50 per cent of the bronchogenic carcinomas arise in a main stem or lobar bronchus. The earliest symptom of a lesion in this location is one of bronchial irritation, namely a chronic cough, usually non-productive. If there has been a pre-existing cough, some change in its character of frequency may be noted. After a variable interval, other symptoms arise because of an increasing degree of bronchial obstruction which interferes with air exchange or bronchial drainage or both. The lesser degrees of bronchial obstruction may give rise to a wheeze, which can often be localized by the patient to one side or the other, and is more or less continuous until the obstruction becomes nearly complete.

Impairment of the normal mechanisms of bronchial drainage result in secondary infection, which may at first resemble one of the common acute lower respiratory infections. Often such acute episodes appear to subside under medical treatment, but there remains a persistent cough, often productive of purulent sputum. Blood-streaking or hemoptysis is thought to occur more frequently in the early phase of the disease, if the lesion is in one of the larger bronchi.

A beginning carcinoma in a main or lobar bronchus gives rise to no abnormal physical findings. It is now generally recognized that abnormal physical signs as well as roentgen findings, when they first appear, are likely to be those of some degree of bronchial obstruction, the presence of tumor being suspected only because of its effect on air exchange or bronchial drainage. As appreciable degrees of bronchial obstruction develop, the asthmatoid wheeze described by Chevalier Jackson, best heard at the open mouth near the end of a forced expiration, may be heard and auscultation may show a unilateral wheeze. Further increase in the degree of bronchial obstruction is accompanied by an interval when the check valve mechanism gives rise to signs of obstructive emphysema. This period is a brief one, since the obstruction soon becomes complete, and the signs of emphysema are soon succeeded by those of atelectasis.

As would be expected, an incipient lesion in a main or lobar bronchus may give rise to no positive roentgen findings.

Case 1.—This patient, a physician of 52 years, had a chronic cough, productive of small amounts of mucoid sputum, for about five months. Blood-streaking had been noted on several occasions, although there had been no actual hemoptysis. The findings on physical examination were negative, and radiography of the chest, including fluoroscopic examination, was negative. However, the bronchoscopy showed a nodular area along the wall of the left main bronchus which proved on biopsy to be a squamous cell carcinoma.

Comment.—It is quite evident that symptoms alone may be sufficient indication for bronchoscopy, but unfortunately, there is a general tendency to defer such examination if the x-ray findings are negative or equivocal. Obviously, the very lesions which show no early roentgen change are those which arise in the larger bronchi, and are therefore accessible bronchoscopically almost from the beginning.

Case 2.—This patient, a man 57 years old, gave a history of chronic cough, attributed to smoking, of several years duration. Although his x-ray was reported negative, his physician insisted that he have bronchoscopy, and it was found rather unexpectedly that he had a carcinoma of the right upper lobe bronchus.

Comment.—It has been our teaching that unexplained chronic cough, even with a negative x-ray examination is sufficient indication for bronchoscopy. This case illustrates another important point, namely that complete examination of the bronchial tree requires use of telescopes to examine portions which could otherwise not be seen. All of the accessible bronchi, including those of both upper lobes, should be examined routinely, whether or not the x-ray shows any localizing density.

In another case, confusion arose because the patient's symptoms and x-ray findings appeared characteristic of "bronchial asthma". Although his wheezing had at first seemed to be paroxysmal, and responded to medications, he was not referred for bronchoscopy until the wheezing became continuous. The radiographs in this case showed findings compatible with the so-called "bronchial asthma," in that diffuse emphysema and fibrosis were observed. We found, however,

that this man had a partially obstructive carcinoma of the right main bronchus. Wheezing should be regarded as one of the cardinal indications for bronchoscopy, even in cases where the symptoms have been attributed to diffuse bronchial infection or allergy.

Case 3.—This patient, a white man of 46 years, had been treated initially for "virus pneumonia" but for the following six months, had had persisting chronic cough, with expectoration of small amounts of purulent sputum. He was referred with a tentative diagnosis of bronchiectasis, since the x-ray showed a stringy or mottled type of density often associated with this condition. On bronchoscopy, it was quite evident that the persisting symptoms, as well as the x-ray findings, were due to a partially obstructive lesion of the right lower lobe bronchus, which had impaired the normal mechanisms of bronchial drainage. The biopsy showed a rather well differentiated squamous cell carcinoma, and examination of the surgical specimen following pneumonectomy showed that the carcinoma was localized to a portion of the bronchial wall, without extension into the adjacent parenchyma. It is now more than five years since the operation, and the patient appears to be cured.

Comment.—It is interesting that many patients of this type are referred with a tentative diagnosis of bronchiectasis and a request for bronchography. It is quite apparent that bronchography should not be regarded as a substitute for bronchoscopy, but should be considered a supplementary examination. Any patient whose symptoms warrant bronchography should also be examined by bronchoscopy, not only to determine by direct inspection the presence or absence of bronchial obstruction but also obtain material for laboratory study. Although Farinas has proposed a classification of bronchial tumors based on their bronchographic appearance, dependence can not be placed on this procedure in ruling out an early neoplasm of the bronchial wall.

Case 4.—This patient, a woman of 38 years, had complained of cough, continuous wheezing of several months duration, and hemoptysis. The roentgenographic findings were those of obstructive emphysema of the left lung. This, of course, was indicative of an obstructive lesion in the left main bronchus and the biopsy was reported "adenocarcinoma".

Comment.—The phenomenon of obstructive emphysema may be observed in cases where the degree of bronchial obstruction is nearly complete, particularly if the lesion is a pedunculated one, so that a large portion of the bronchial wall is free to widen in the inspiratory phase, allowing air to enter; the bronchus of course becomes narrower during the expiratory phase, so that egress of air is prevented, and the lung remains distended. This phenomenon, of course, is observed most dramatically on fluoroscopy.

Naturally, when bronchial obstruction becomes complete in both phases of respiration, the roentgen findings will be those of atelectasis, whether of the lung, the lobe or the bronchopulmonary segment. Occasionally, the opinion is expressed that bronchoscopy will be of no value if the x-ray shows a lesion in the upper lobe. However, it is well known to everyone who does bronchoscopy that telescopes of the right angle or retrograde type will allow detailed inspection of both upper lobe bronchi, and even if tissue cannot be obtained for biopsy in such cases, it is possible to obtain material for cytologic study by aspiration of the bronchus adjacent to the lesion. Furthermore, in any case where surgical treatment is being considered, it is important to determine by bronchoscopy not only the condition of the portion of the bronchial tree where a lesion is suspected, but also to inspect carefully the main bronchi and carinal region for direct or indirect evidence of inoperability.

Finally, in cases of pulmonary abscess or empyema, it must be recognized that the underlying cause may be some type of bronchial obstruction. Bronchoscopy, of course, should be a part of the routine study of any patient in whom the x-ray findings suggest a suppurative pneumonitis or pulmonary abscess.

Let us now consider briefly the manifestations of a carcinoma arising in the segmental bronchus. The cases which may be included under this group constitute an important series. Here the diagnosis can be made early, though with somewhat greater difficulty than in cases where the larger bronchi are involved, and the incidence of operability is rather high. A lesion arising here will obstruct the segmental bronchus almost at the start, and for this reason the symptoms have their onset in a more or less acute febrile illness due to obstruction and secondary infection. Although the physical signs may not be remarkable, roentgen examination may show abnormal density or atelectasis confined to a single bronchopulmonary segment; there will be a wedge-shaped area extending peripherally from the hilus.

Case 5.—This patient, a man of 50 years, had been treated for pneumonia and when his symptoms persisted, a radiograph was found to show atelectasis of the posterior basal segment of the right lower lobe. The initial bronchoscopy showed nothing obstructive in the right lower lobe bronchus, but a subsequent bronchogram demonstrated occlusion of the posterior basal segmental bronchus a short distance from its point of origin. At the time of the second bronchoscopy, although the lesion was found to be beyond

the segmental branching, a specimen of tissue was obtained by inserting a small forceps into the posterior basal segmental bronchus. The lesion was a squamous cell carcinoma, and pneumonectomy was subsequently performed.

Comment.—Roentgen evidence of a segmental atelectasis is as important and as strongly suggestive of bronchial occlusion as is lobar atelectasis. If this fact is recognized, and if every effort is made to obtain material for histologic diagnosis, many of these lesions can be proven while still operable. The relative constancy of the segmental bronchial anatomy, whose terminology is now quite well standardized through the efforts of Jackson and Huber and others, facilitates a correlation of roentgen findings with the bronchoscopic approach in such cases. If possible, one should determine in advance, in which segmental bronchus the abnormal density lies, so that particular care can be given the inspection of this area during the bronchoscopy.

In cases where an actual tissue specimen for biopsy is not obtainable, secretions are removed for cytologic study. Bence has described the use of bronchial lavage in obtaining material for microscopic examination by this method, and Perez has devised a special "broncho-catheter", introduced under fluoroscopic guidance, to obtain material from the segmental bronchi.

Difficulties in differential diagnosis frequently arise in cases where the lesion involves a segmental bronchus.

Case 6.—This patient, a man 27 years old, complained of slightly productive cough, expectoration and blood-streaking. In view of his age and the roentgen evidence of stringy density in the posterior segment of the upper lobe, tuberculosis was considered as the most likely possibility. He was referred to a sanatorium where pneumothorax was given, although sputa had been consistently negative. The initial bronchoscopic examination had been negative, and nearly six months had elapsed before the diagnosis of carcinoma was established by microscopic examination of the sputum.

Comment.—It must be recognized that negative cytologic findings do not rule out the possibility of carcinoma. If confirmation of a suspected diagnosis cannot be obtained by repeated cytologic studies, exploratory operation may be required. Another source of confusion may arise in cases where the x-ray shows apparent improvement in a segmental lesion as judged by the size of the area of abnormal density. For example, a patient who had been treated for pneumonia of the left upper lobe, was found initially to have a rather large area of homogeneous abnormal density in the anterior portion of the left upper lobe. He had improved with an antibiotic treatment, and a subsequent x-ray was thought to have shown improvement because of a decrease in the size of the abnormal density. Subsequent developments indicate however, that this represented simply successive stages in the occurrence of segmental atelectasis. In the early stage, comparable to the "drowned-lung" which occurs during the early stage of complete bronchial obstruction, the airless segment occupied a much larger area than later, when further volume loss had occurred leaving only a narrow band of abnormal density. In this case, the diagnosis was made by cytologic study and resection performed.

I should like to direct attention to the fact that in none of the cases presented up to this point have the x-rays shown a shadow which can be attributed to the tumor itself. In other words, the roentgen manifestations have been those of bronchial obstruction, and the presence of tumor was suspected only because of the changes which occurred as a result of impairment of bronchial drainage or aeration through some degree of bronchial obstruction. Of course, in some of these cases, planigraphic study of the larger bronchi might have shown the presence of an obstructive bronchial lesion. However, planigraphy, like bronchography, is regarded as a supplementary type of examination, which may in some cases give additional information after the bronchoscopy has been performed.

The carcinomas arising in the peripheral bronchi have been appropriately called "silent" tumors, for they frequently attain a considerable size without giving rise to pulmonary symptoms. Phenomena relating to bronchial obstruction usually do not occur, so that atelectasis and secondary infection are not encountered, although there may be cavitation within the tumor itself. The presenting symptoms in cases of this group are often extra-pulmonary; symptoms attributed to metastasis to the brain, bones, or other parts of the body may precede those of the primary lesion. Pain due to invasion of the parietal structures may also be the first manifestation.

Tumors of this type may be discovered as a part of routine study, or may be found initially in survey studies which are being applied to industrial or other groups. The peripheral tumors, which constitute about 25 per cent of all bronchogenic carcinomas, are generally not accessible to bronchoscopic biopsy. In some cases, the diagnosis may be made by cytologic study, and if confirmation of the diagnosis is not obtained by this method, aspiration biopsy (needle biopsy), performed under guidance of the biplane fluoroscope, may

be used with success in proving the biopsy. The incidence of positive biopsy by this method is about 66 per cent, but it is used only where the simpler methods of obtaining a histologic diagnosis has not been positive.

In the opinion of some thoracic surgeons, the method of needle aspiration biopsy is not advisable; it has been suggested that there is danger of disseminating tumor cells along the needle tract. However, in the considerable experience of the Memorial Hospital in New York, such an occurrence has not been observed, and we have likewise not observed any incidence of such a complication. There appears to be very little risk of disseminating infection, and although a pneumothorax has occurred in occasional cases, this has rarely been of sufficient degree to require removal of air from the pleural space.

If a positive diagnosis can be established by needle biopsy when other methods fail, the necessity for confirming the diagnosis at the time of exploratory operation is eliminated, so that there is no need for deciding on the indications for resection on a basis of the gross findings, and likewise no need for cutting into the lung for frozen section. It would appear that the risk of disseminating tumor cells is greater if a frozen section technique is used, than in the case of a previously performed needle biopsy.

In cases where histologic proof of a suspected diagnosis of bronchogenic carcinoma is not obtainable, exploratory operation should be advised. Obviously, further delay under such circumstances may allow a potentially resectable lesion to become inoperable. With modern surgical techniques, and improved techniques of anesthesia, the risk of exploratory thoracotomy is only slightly greater than that of abdominal exploration. Naturally, the operative risk in each case must be estimated on a basis of the cardiovascular findings and pulmonary function tests.

Summary and Conclusions

1. The early symptoms, physical signs and roentgen findings in bronchogenic carcinoma depend chiefly on the point of origin in the bronchial tree. The early manifestations have been discussed in connection with illustrative cases of tumors arising in main or lobar bronchi, in segmental bronchi, and in the peripheral portion of the bronchial tree.

2. Chronic cough, hemoptysis and wheezing should be regarded as indications for bronchoscopy, even though the x-ray findings may be negative.

3. Early roentgen findings in carcinoma of the bronchus are those resulting from bronchial obstruction, except in the case of peripheral tumors. A bronchial lesion should be suspected in the presence of abnormal density of lobar or segmental distribution, as well as in the presence of obstructive emphysema or atelectasis of lung, a lobe or bronchopulmonary segment. Except in the case of peripheral tumors, the actual tumor is rarely observed on the roentgenogram in the early stages of the disease.

4. Cytologic studies of bronchial secretions have been particularly helpful in confirming the diagnosis of carcinoma arising in a segmental or peripheral bronchus. The roentgenograms should be carefully studied before bronchoscopy, so that material for cytologic study can be obtained from the identified segmental bronchus.

5. Needle aspiration biopsy under fluoroscopic guidance is a useful method of obtaining histologic diagnosis in cases where the diagnosis can not be made by material obtained bronchoscopically.

6. Exploratory thoracotomy is indicated in cases where there is convincing clinical evidence of bronchogenic carcinoma, even though a proven histologic diagnosis cannot be obtained, provided there is no evidence of extrapulmonary invasion or metastasis.

Challenge to Schools Presented

It is not enough for a physician, or any professional, to be well-trained. He must be well-educated, too. He must and should have a great interest in his professional societies and organizations, but he belongs to a larger club within a still larger club. He has to have, or to be able to claim, membership in a society of educated men who can converse beyond the small vocabularies of their specialties. And he has to know the full meaning—not just the chemical, physical, or anatomical meaning—of belonging to the human race.

For this membership, his training in science has only half prepared him. It is our job, in the schools and colleges—before professional and graduate schools claim him for science forever—to give him those insights and perspectives, in history, literature, language, math, art, philosophy, and music, which will enable him to live more richly as both man and physician.—William H. Cornog, Ph.D., Superintendent of Schools, New Trier High School, Illinois.

A Reappraisal of the One-Stage Resection For Diverticulitis of the Colon

Charles A. Sanislow, M.D.
Robert E. L. Berry, M.D.
Ann Arbor, Michigan

IN RECENT YEARS there has been an evolution toward a bolder approach to the surgical treatment of diverticulitis of the colon with an increasing utilization of the primary one-stage resection. The advantages of the successful single-stage procedure need not be elaborated. It is *not* our desire to disclaim this approach, but rather to reflect upon and emphasize the need for a careful selection of the patients on whom this procedure is performed. The manifestations of diverticulitis ranging from locally involved asymptomatic areas of the sigmoid colon to extensive intrinsic and percolic inflammation of the entire left colon, preclude a dogmatic approach to this problem.

TABLE I. THERAPY OF DIVERTICULITIS OF THE COLON 1934-1960

Operative Procedure	Number of Patients
One stage resection	48
Three stage procedures	45
Two stage procedures	6
Colostomy only	14
Cecostomy only	4
Combined A. P. resection	3
Ileo-ascending colostomy	1
Obstructive resection	3
I and D-pelvic abscess	4
Total	128

Operative therapy utilized in 128 cases of diverticulitis of the colon 1934-1960.

During the period 1934-1960, 128 patients were operated upon at the University of Michigan Medical Center for diverticulitis of the colon. The operated group constituted 33 per cent of all patients diagnosed as having clinically significant diverticulitis. Over this 26-year interval, there were 48 primary single-stage resections and 45 three-stage procedures. The remaining patients were treated with two-stage procedures, colostomies, cecostomies, abdominal-perineal resections or merely incision and drainage of pelvic abscesses (Table I).

In the group treated by a single-stage resection, there was one death and 16 major complications; these included five anastomotic leaks, four deep-wound abscesses with necrotizing fasciitis, and one wound dehiscence (Table II). Disruption of the anastomosis occurred in a setting of extensive inflammatory disease involving the left colon proximally and distally to the resected segment, yet it was in the face of this inflammation that a single-stage resection was performed. These findings were recorded at the time of operation and confirmed by the microscopic examinations of the resected specimens. The complication rate of the remaining 80 patients not treated by primary resection was less than 15 per cent.

TABLE II. SIGNIFICANT COMPLICATION FOLLOWING PRIMARY ONE-STAGE COLON RESECTION (Thirty-Eight Patients 1934-1960)

Complication	Number of Patients
Anastomotic leak	5
Post-operative obstruction	2
Wound abscess	4
Injury to other abdominal viscera	1
Dehiscence of wound	1
Post-operative hemorrhage	2
Failure of cecostomy to close	1
Total	16

Significant complication following primary one stage resection.
16 complications in 48 patients, an incidence of 33 per cent.

The radiologic interpretation of "diverticulosis with some evidence of diverticulitis" did not reflect the inflammatory changes seen at the time of operation. The degree of colonic involvement was invariably more extensive than preoperative contrast x-rays revealed. Only inspection of the colon at the time of operation provides an accurate estimate of the degree of involvement but even such a minute examination

From The University of Michigan Medical Center, Department of Surgery, Ann Arbor, Michigan.

At present, Doctor Sanislow is serving as Capt. USAF, Chief Surgeon, 551st USAF Hospital, Otis AFB, Massachusetts.

does not preclude tedious dissection and a tenuous anastomosis.

Colonic diverticulitis can be divided into three general groups as seen at the time of operation. The operative findings in each of these proposed categories strongly suggest the procedure of choice:

1. The localized inflammatory lesion seen in the sigmoid colon with normal appearing bowel above and below the area of involvement with minimal inflammation of the mesentary. This lesion will be difficult to distinguish from a neoplasm, but is usually resectable and presents few problems with regards to the continuity of the anastomosis. Under these circumstances, the primary single-stage resection has its safest application.

2. The colon which is diffusely involved with intrinsic and pericolic inflammation extension into the recto-sigmoid area, creates a need for a decision which may be extremely difficult and troublesome. In this setting, five anastomotic leaks occurred. The amount of normal tissue distal to the lesion is a most important factor in determining the safety of a primary anastomosis. Where diffuse involvement of the left colon exists one seldom finds the situation amenable to a safe, single-stage colon resection.

3. In the last group are the patients who present with acute perforations, or pelvic abscesses with or without acute obstruction. These individuals may be acutely ill and only a diverting colostomy and drainage should be performed. A cecostomy is an inadequate method of decompression because complete diversion of the fecal stream is mandatory.

The success of primary resection requires adherence to certain fastidious principles of colon surgery. These are briefly as follows:

1. Proper preparation of the bowel is essential (mechanical and nonabsorbable antimicrobials).
2. Lack of tension at the anastomosis by adequate mobilization.
3. The site of colon chosen for the anastomosis should be free from edema, induration, thickening, and inflamed pericolic fat.
4. Care in the toilet of the wound.
 (a) Absence of fecal contamination
 (b) Copious irrigation
 (c) Absolute hemostasis
 (d) Minimum of suture material in the subcutaneous fat.

After all precautions are accomplished, should there be any doubt on the part of the surgeon as to the security of the anastomosis, a proximal colostomy should be performed.

Summary

Experiences with 128 cases of surgically treated diverticulitis have been presented; 48 patients were managed by single-stage resections, attended by a 33 per cent incidence of major complications. The remainder of this series, those whose disease by history and examination was extensive and who received more conservative operative procedures, suffered less than a 15 per cent incidence of comparable complications with no deaths. *The practicality of the single-stage resection is affirmed, but a cautious approach is suggested in its application.* The difficulty in predicting the degree of inflammatory involvement preoperatively has been emphasized; each case should be individually evaluated and any dogmatic approach to surgical treatment should be avoided. There remains an ever-present need for the older and more conservative multiple-staged approach in certain cases of non-localized diverticulitis. *Primary single-stage resections should be limited to those cases of diverticulitis with localized disease.* A plea is made for minute attention to preoperative preparation, fastidious operative techniques, and wound cleansing.

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Addition of Hydriotic Acid in the Treatment Of Respiratory Distress

A. R. Ceresko, M.D.
Detroit, Michigan

THERE IS NO REPORT in medical literature concerning the use of hydriotic acid in the dosage here reported as a complement in the present treatment of respiratory distress.

Having had success in treating a number of cases of respiratory distress over the past five years with no deaths in non-pediatric hospitals, I was happy for the opportunity to study the following case of respiratory distress in a slightly more complete manner.

Case Report

D. G., a girl, born of a pregnancy which was one week short of seven months, weighed 3 pounds and 7 ounces.

The mother had had three previous pregnancies all going to full term giving birth to three normal girls. This pregnancy was uneventful except for its sudden and unexpected termination. The mother went into spontaneous labor and reached the hospital in time. The obstetrician felt that it would be a stillbirth because no fetal heart-tones could be heard, but he carefully delivered the infant, and the baby gave a weak cry immediately upon delivery. The cord was tied and the baby was taken to the nursery and placed in cold steam oxygen.

I saw the baby about 45 minutes after birth. The baby showed peripheral cyanosis, and her lips were cyanotic even in the oxygen which was running at 2 liters per minute. Muscle tone was fair. Moro and grasp reflexes were fair. Respirations were labored with a moderate grunt present.

There was a mild amount of thick mucus in the mouth and pharynx. Heart sounds were of good quality and no murmur could be elicited.

The heart rate was 140. There were fine râles scattered throughout both lung fields and the air exchange was very poor.

The child was transferred to Children's Hospital in a premature ambulance at about three hours after birth. A radiograph taken on admission showed a diffuse nodular and hazy appearance of both lung fields. In the lateral and frontal projection, air bronchogram was visualized. The radiologist was of the opinion that this represented characteristic findings of hyaline membrane disease. The infant was placed in cold steam O_2 at 1 to 2 liters per minute. A dose of Bicillin all purpose 150,000u was given intramuscularly on the first day and repeated the second day. Demethyl chlortetracycline, 6 milligrams, was given stat followed by 3 milligrams every six hours and continued four days In addition 1 cc of syrup of hydriotic acid was given every four hours.

At 20 hours, the infant had shown signs of improvement. Scattered fine râles were still heard, but breathing was definitely less labored and the air exchange was definitely improving. The heart remained good, and no murmurs were heard.

At 44 hours, the lungs had definitely improved again. There was no longer any labored breathing. Air exchange was good, and only a few scattered râles were heard. At this time, Prednisolone 0.1 mgm every six hours by hypodermic injection for four doses was ordered. The baby was now started on glucose water by gavage. Weight was now 3 pounds, 2 ounces, which is the lowest it had gone. The cyanosis was no longer present, but the infant did begin to display some icterus at this time. The bilirubin was checked at 12-hour intervals and at the fourth day showed a high of 11.7 mgm per cent total bilirubin, after which it returned to normal by the ninth day.

At 70 hours, the baby was started on the routine formula. The infant was active non-cyanotic. Oxygen was discontinued, and the color remained good. Air exchange was good. At this time the hydriotic acid was discontinued. Demethylchlortetracycline was discontinued the following day.

The infant progressed well and was discharged on its 35th day, weighing 5 pounds 2.5 ounces.

A radiograph of the chest on the eighth hospital day revealed the diaphragms somewhat low in position with no evidence of free pleural fluid. There were multiple areas of mottled increase in density throughout both lung fields which the radiologist felt might indicate focal areas of atelectasis, bilateral inflammatory process or hyaline membrane disease. On the 15th hospital day another X-ray revealed again the mottled densities throughout both lung fields but not as diffuse at this time. Diaphragmatic leaves were up to normal. Air bronchogram was still noted outstandingly in lateral projection. In all slight improvement was noted and an impression of compatibility with focal atelectasis or hyaline membrane disease. On the 21st hospital day reexamination of the chest again revealed prominence of hilar bronchiovascular markings throughout both lung fields but it was felt that the small areas of focal atelectasis or hyaline membrane disease had now resolved.

Discussion

It appears that the syrup of hydriotic acid given in comparatively large and yet entirely safe dosage—

certainly no thyroid effect could be achieved in two to three days—helps in causing dissolution of the hyaline membrane in the active lung fields where secretion of the iodide into the alveoli is achieved. The mottled appearance, thereafter possibly represents the inactive lung where alveolar exchange is not taking place. However, once enough oxygen exchange area is achieved, the body makes no further demands on the lung immediately and resolution of the remaining membrane is done in normal processes of the body in approximately three weeks. Certainly from an auscultatory point of view, the lungs were normal after the fourth day.

With so small a series, no claim is being made that this may not be a statistical coincidence. However, this case is being presented for the suggestion of the use of this innocuous drug in addition to already available armamentaria for further and more complete evaluation of its possible and probable merits.

WSU Alumni Reunion Guest Speakers

Eight papers will be presented at the 95th alumni reunion and clinic day of Wayne State University's College of Medicine in the Sheraton-Cadillac Hotel, Wednesday, May 8.

Out-of-state speakers and their papers will be: Mark M. Ravitch, M.D., surgeon in chief, Baltimore City Hospitals, "Surgical Management of Ulcerative Colitis"; and, Joseph B. Kirsner, M.D., professor of medicine, University of Chicago, "Current Views on the Management of Peptic Ulcer."

The other six speakers are from the WSU College of Medicine. They are: Thomas A. Bruce, M.D., assistant professor of medicine, "Evidence for the Reversibility of the Atheromatous Plaque"; Muir Clapper, M.D., professor of medicine, "Diagnosis and Treatment of the Tachycardias and Arrhythmias"; Elliot D. Luby, M.D., associate professor of psychiatry, "Current Research Concept in Schizophrenia"; Alan P. Thal, M.D., professor and chairman, department of surgery, "Surgical Management of Acquired Heart Disease."

Others include Paul V. Wooley, Jr., M.D., professor and chairman, department of pediatrics, "The Value of Chromosomal Studies in Clinical Medicine," and Clifford D. Benson, M.D., associate professor of surgery, "Intussusception in Infants and Children: An Analysis of 300 Cases."

MICHIGAN DEPARTMENT OF HEALTH

ALBERT E. HEUSTIS M.D., State Health Commissioner

Quadruple Vaccine Available

A four-way vaccine which protects against diphtheria, pertussis, tetanus, and paralytic polio is now available from the Michigan Department of Health. The new product adds Salk polio vaccine to the present triple—DPT—vaccine which has been produced by the Department and distributed, without charge, to Michigan physicians and health departments since 1948.

Work on the quadruple vaccine has been going on at the Health Department Laboratories for the past two years following legislation which provided funds to assist in the fulfillment of conditions imposed by Acts 12 and 121 of the Public Acts of 1960. Act 12, P.A. 1960, established the so-called school checkpoint law requiring that parents or guardians of all children entering school show proof of immunization against smallpox, diphtheria, pertussis, tetanus, and poliomyelitis or request that such immunizations be given by the local health department or submit a statement that immunization has not been done because of religious or other reasons. Act 121, P.A. 1960, amended the basic immunization law which provides for free immunization of children, to include polio, along with DPT and smallpox.

A number of production problems had to be overcome before the new vaccine was perfected. Chief among them was the fact that by adding Salk vaccine to DPT, the pertussis component was rendered less potent. However, by modifying certain laboratory production techniques, a way was found to maintain potency in the pertussis component and the vaccine was released for distribution at the end of January. The Michigan Department of Health recommends that no product it manufactures be used after the expiration date recorded on the package.

Last year in Michigan reports indicate there were 4 cases of diphtheria and 2 deaths, 1756 cases of whooping cough and 2 deaths, 8 cases of tetanus and 4 deaths, 19 cases of paralytic polio and 1 death. The paralytic polio record contrasts sharply with the 1952 record of almost 2000 cases and over 200 deaths and is striking evidence of the efficacy of the vaccine. Unquestionably, the crippling and death which occurred in 1962 from these preventable diseases could have been largely, if not entirely, prevented had the individuals concerned received adequate immunization.

Quadruple vaccine has the advantage of combining diphtheria toxoid, tetanus toxoid, pertussis vaccine and poliomyelitis vaccine in a single *one cubic centimeter dose which should be given intramuscularly.*

It is hoped that the availability of this new product, which will simplify standard immunization procedures, will greatly increase the number of children receiving their basic immunizations against polio, tetanus, diphtheria, and pertussis. Quadruple vaccine is primarily intended for basic immunization of the infant and preschool child.

The ultimate decision as to the immunizing procedure to be employed rests with the physician. A satisfactory schedule for quadruple vaccine starting at three months of age is as follows: the first dose is given at three months, followed by a dose at four months, and at five months. The fourth or reinforcing dose is given seven months later at age one. When quadruple vaccine is used for booster injections, the full one cubic centimeter dose is necessary in order to obtain adequate response from the poliomyelitis component. This occasions reactions in a very few individuals since this dose of quadruple contains full doses of diphtheria toxoid and pertussis vaccine.

Older children and adults may have severe reactions from quadruple and its use should therefore be largely limited to immunization of children six years and under.

Smallpox vaccination may be done at any time during the first year of life. Four months is suggested so that results can be noted when the child returns at five months of age for the third dose of quadruple vaccine. Revaccination against smallpox should be performed at five years of age.

Complement Fixation Tests for Blastomycosis, Coccidioidomycosis, and Histoplasmosis

A new diagnostic service has been provided by the Michigan Department of Health. As of February 1, 1963, complement fixation tests for blastomycosis, coccidioidomycosis, and histoplasmosis are being performed by the Division of Laboratories. Physicians requesting such tests should send specimens, accompanied by a Miscellaneous Examinations (F22) form, to Michigan Department of Health, Division of Laboratories, 3500 North Logan, Lansing 4.

MCCC Coordinates Cancer Efforts

By B. E. Luck, D.D.S., *Chairman*

Michigan Cancer Coordinating Committee

This excellent Cancer Number of The Journal of the Michigan State Medical Society is another proof-positive of the cooperative efforts of the Michigan Cancer Coordinating Committee. The MCCC thanks the MSMS for its day-in-and-day-out cooperation and especially for this fine educational series of articles for Michigan M. D.s to study.

More than 100,000 men, women and children have died of cancer in Michigan over a 10-year period. A disease that exacts so great a toll in one state is an enemy worthy of the best coordinated and organized opposition.

Until a few years ago, professional and public education on cancer was left pretty much to the consciences of individual agencies. On November 12, 1953, six Michigan agencies sent representatives to begin the Michigan Cancer Coordinating Committee. For the first time, the educational effort was unified.

Joining in this new effort were the Michigan State Medical Society, Michigan State Dental Society, Michigan Department of Health, American Cancer Society—Michigan Division; American Cancer Society—Southeastern Michigan Division, and the Michigan Health Officers Association. Since then, the Michigan Cancer Foundation has added its weight to the total movement.

The MCCC now carries on an active program, which includes printing and distribution of literature, maintaining a speakers bureau, sponsoring various projects, exhibiting before many professional and public organizations, etc.

The Michigan Cancer Coordinating Committee directs a powerful force against cancer in Michigan. The MCCC leads an attack against Cancer by slashing at its four fronts—fear, apathy, ignorance and quackery.



Community Relations

By Donald R. Bryant, M.D., *Editor*

Genesee County Medical Society Bulletin

Business people and the general public have the impression that doctors are not doing their share in community government, social welfare, cultural, social and educational affairs. The physician apparently is in a unique position since most people have trust and confidence in the doctors' judgment. They will accept advice from their doctor on many things other than medical care.

The future holds many changes for all of us. If we want it to be a good world to live in and a better world for our children, we must act now. The physician has a stake in the future of his community. Our population expansion means a more complex society with more, rather than less government. Our responsibility lies in an advisory capacity for education, law enforcement and local government. Some

of our state officials feel that the local medical society must take a hand in local welfare planning, especially in an advisory capacity.

If you can't get out and work for your community then you must help out as an advisor in some capacity. Be sure that you can answer your patients' questions on civic affairs. Above all become familiar with the differences between Kerr-Mills (MAA) and the King-Anderson Bill. This will be an issue again this year and is the first thing that we should discuss with all our patients. A judicious word or two can start a trend of thought favorable to the future of private medicine.

Important Work Continues

By Harold F. Falls, M.D., *Chairman*
MSMS Medical Socio-Economics Committee

The efforts of Medical Socio-Economics committees appointed by component societies and the specialty groups have been productive during their first year of existence.

Such committees present a new venture by medical organizations and there are no set patterns to follow. Considerable study and thinking must be formulated before decisions can be reached and projects launched.

It is the sincere wish of the MSMS Committee on Medical Socio-Economics that more component societies and specialty societies appoint such committees. There is a true need for such 'grass-roots' efforts!

The importance of their work is captured in the annual report of the Kent County Medical Society Medical Socio-Economic Committee. In part, the report states:

"The Socio-Economic Committee cannot work alone. The united efforts of every member are needed in our fight to preserve our way of life, and to combat the many vicious elements at work."

The report further contended that "as members of organized medicine, we must all do our utmost to carry our message to the people, to our patients, and to educate them to the realization that social legislation of the King-Anderson type is not in their best interest."

"See You in Atlantic City"

By George M. Fister, M.D., *President,*
American Medical Association

The American Medical Association will hold its 112th annual meeting June 16-20 at Atlantic City. In urging you to attend, I would like to write briefly about an aspect of science that is rapidly becoming a very serious problem. I refer to what scientists have called "The Publication Explosion."

Research men are faced with the dictum of "publish or perish." Naturally, they publish. There were four million scientific documents published in 1962. These included some three million papers and articles in some seventy thousand technical and professional journals. The bulk of these are in the life sciences, particularly medicine.

It has been said that it would be necessary for a physician to read one book an hour just to keep up with new findings in his own specialty. This obviously is impossible.

Such scientific meetings as the AMA Annual Meeting help to keep the physician abreast of new developments. At the AMA annual meeting, in a short space of four or five days the physician has his choice of literally hundreds of scientific papers covering the broad spectrum of medicine. He can select half a dozen lectures daily from the program as a whole. Or he can concentrate on his specialty section and its meetings.

It would take years of reading an hour a day to learn all that can be learned in five days at the annual meeting of the American Medical Association.

As president of the American Medical Association, I personally urge every American physician to make plans now to attend this AMA annual meeting in Atlantic City to help carry the findings of research into everyday practice.

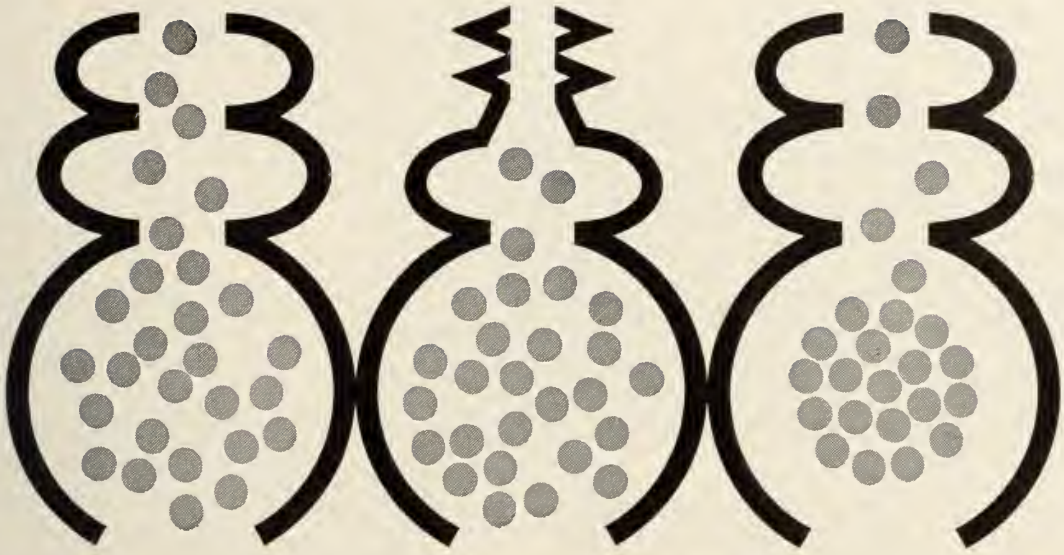
Honors to Michigan Doctor

John T. Hayes, M.D., of the University of Michigan Medical Center has been selected as one of four orthopedic surgeons in the United States to be guests of the British Orthopedic Association in April 1963. The honor is a result of an international professional exchange program worked out between the B.O.A. and the American Orthopedic Association, according to Carl Badgley, M.D., head of orthopedic surgery at the University of Michigan.

Doctor Hayes will spend about two months in Britain viewing their procedures and techniques, and will deliver special reports of American methods. He is the second University of Michigan surgeon to win this distinction in recent years. The first was Robert W. Bailey, M.D., Associate Professor of Surgery, University of Michigan.

Appreciation

We wish to thank most sincerely Wm. Bromme, M.D., of Detroit, for his valuable assistance in assembling the original cancer papers in this issue of The Journal.



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In a recent clinical report Cayer and Sohmer[2] state: "The alleviation of symptoms [with Lomotil] was usually prompt, occurring within 24 to 72 hours even in the long-standing chronic cases. . . . A surprisingly satisfactory response was obtained in 75 per cent of the patients with regional enteritis and in 63 per cent of those with ulcerative colitis, all of whom had failed to respond to other measures."

The high therapeutic efficiency of Lomotil, its safety, convenience and economy may be used to advantage in acute or chronic diarrhea.

Dosage: For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily. Maintenance dosage may be as low as two tablets daily.

Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. Recommended dosage schedules should not be exceeded.

Note: Lomotil is an exempt preparation under Federal narcotic statutes.

Detailed information and directions for use in children and adults are available in Physicians' Product Brochure No. 81. G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

1. Janssen, P. A. J., and Jageneau, A. H.: A New Series of Potent Analgesics: Dextro 2:2-Diphenyl-3-Methyl-4-Morpholino-Butyrylpyrrolidine and Related Amides. I. Chemical Structure and Pharmacological Activity, J. Pharm. Pharmacol. 9:381-400 (June) 1957.
2. Cayer, D., and Sohmer, M. F.: Long-Term Clinical Studies with a New Constipating Drug, Diphenoxylate Hydrochloride, N. Carolina Med. J. 22:600-604 (Dec.) 1961.

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THURSDAY & FRIDAY
MAY 2 & 3, 1963

SYMPOSIUM
ON
"GENETICS
AND
MEDICINE"

HARPER HOSPITAL

PARTICIPANTS

ANIMAL GENETICS AND MEDICINE
DR. EARL L. GREEN — Roscoe B. Jackson Memorial Laboratory

THE CHEMISTRY OF GENE ACTION
DR. H. ELDON SUTTON — University of Texas

CLINICAL ASPECTS AND POPULATION GENETICS OF GLUCOSE - SIX - PHOSPHATE DEHYDROGENASE DEFICIENCY
DR. ARNO MOTULSKY — University of Washington

APPLICATIONS OF CHROMOSOME STUDIES TO VARIOUS MEDICAL SPECIALTIES
DR. MARGERY W. SHAW — University of Michigan

INFECTIVE HEREDITY — THE LESSON OF LYSOGENY
DR. MYRON LEVINE — University of Michigan

GRANDMOTHER'S Rh AND ABO BLOOD TYPE IN RESPECT TO ERYTHROBLASTOSIS
DR. KAZ MAYEDA — Wayne State University

THE HEREDITARY HUMAN GAMMA GLOBULIN GROUPS
DR. M. HUGH FUDENBERG — University of California, San Francisco

GENETIC MACHINERY AND PROTEIN BIOSYNTHESIS
DR. PHILIP HANDLER — Duke University Medical School

THE CONTROL OF METABOLIC REACTIONS AND THE CONSEQUENCE OF ALTERED PROTEIN SYNTHESIS
DR. JAMES B. WYNGAARDEN — Duke University Medical Center

HEREDITY AND THE RESPONSE TO DRUGS
DR. JAY M. ARENA — Duke University Medical Center

CARBOHYDRATES
DR. J. B. SIDBURY — Duke University Medical Center

AMINO ACIDS
DR. JEROME S. HARRIS — Duke University Medical Center

HORMONES
DR. ROBERT S. STEMPFEL, JR. — Duke University Medical Center

LUNCHEON

THURSDAY, MAY 2

WAYNE COUNTY MEDICAL SOCIETY

LUNCHEON

FRIDAY, MAY 3

SHERATON CADILLAC HOTEL

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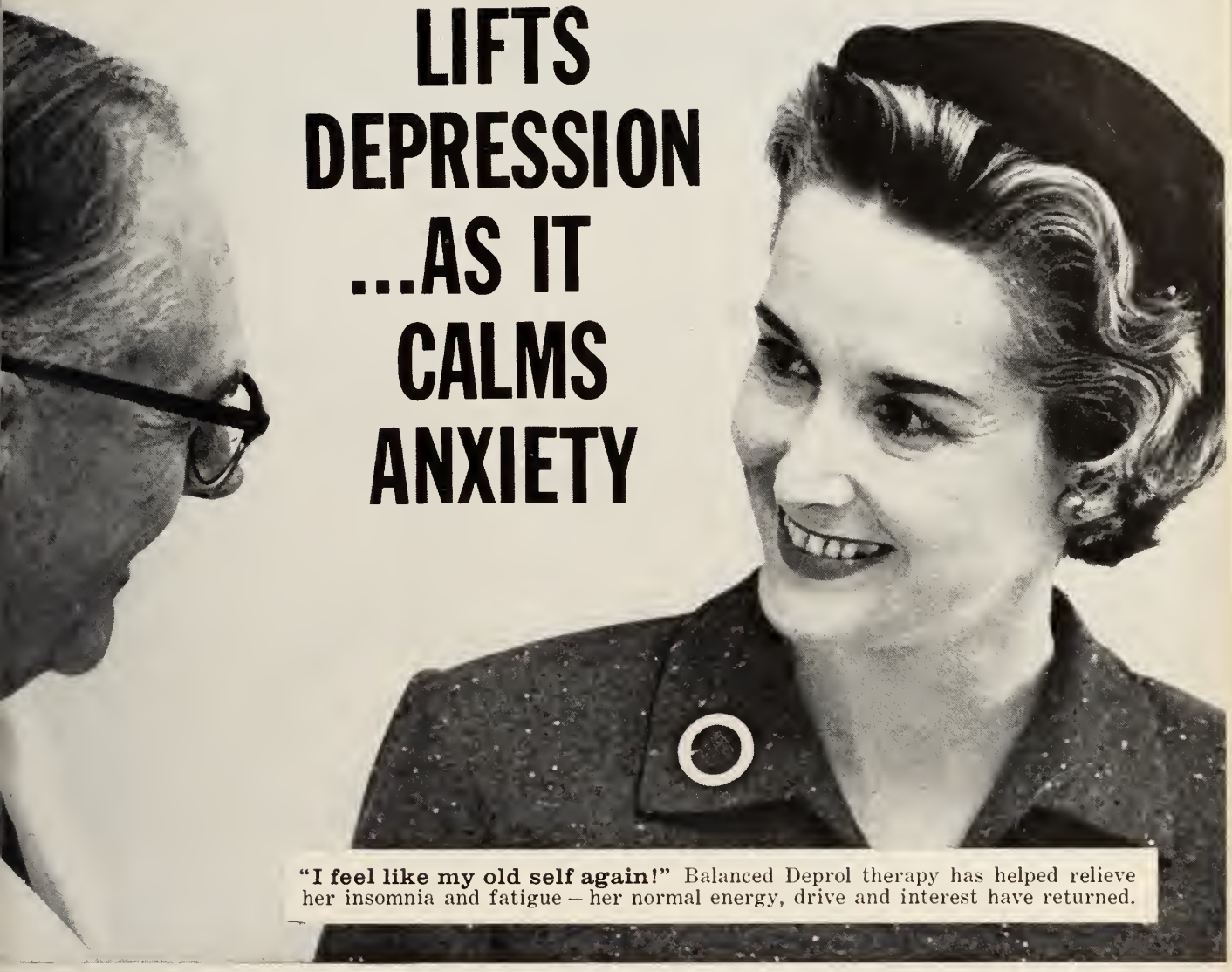
Guest Speaker

MARTIN S. HAYDEN
EDITOR, DETROIT NEWS

"AN EDITOR LOOKS AT THE DOCTORS"

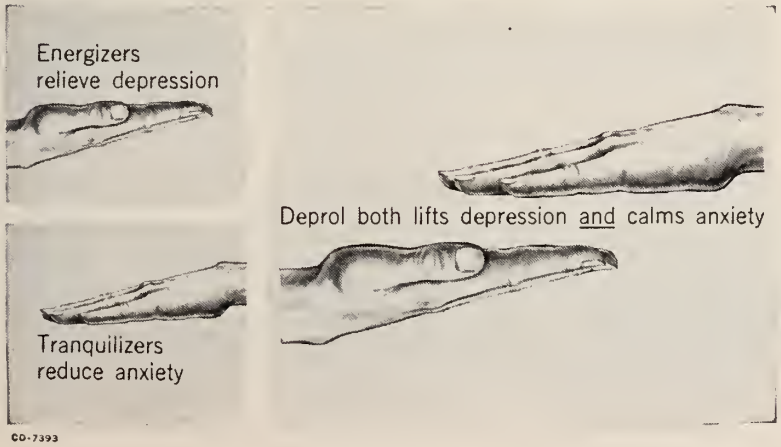
Say you saw it in the Journal of the Michigan State Medical Society

LIFTS DEPRESSION ...AS IT CALMS ANXIETY



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Brightens mood...relaxes tension



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GR Health Fair Set May 19-24

The Kent County Medical Society, assisted by many other health organizations, will present a large Health Fair at the Grand Rapids Civic Center, May 19 through 24. The event formally is being sponsored by the Kent Medical Foundation.

Thousands of Michigan children and adults are expected to visit the action-packed exhibits.

Since this is a Health Fair, the old prescription for Fair success has been changed from cotton candy, peanuts and balloons to live animal surgery demonstrations, space medicine, and two Century 21, World's Fair Exhibits, "Man Against Cancer" and "Dentistry Through The Ages of Man."

Other features will include the nationally famous, American Medical Association's "Plastic Twins," the plastic figures wired so that each organ of the body lights up in sequence with a recorded lecture; "Life Begins," the basic concept of anatomy associated with conception and birth; a "Live Chick Hatchery"; "Survival Car II," designed to give greatest protection in collision; and a lighted model of the "Human Cell."

For students in search of a future, there will be hundreds of professional workers from the various career fields of health to explain and actively demonstrate their profession in Radiology, Pathology, Veterinary Medicine, Nursing, Occupational and Physical Therapy, Pharmacy, and other areas faced with personnel shortages.

In addition to career literature available at the various exhibits, there will be an "Area of Opportunity" for students who wish to explore career possibilities more thoroughly.

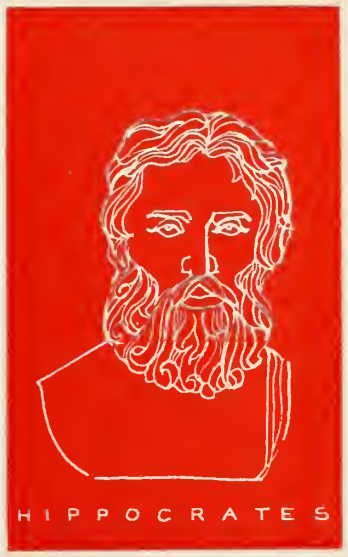
Special tours for students in grades 6 through 10 are being scheduled for those schools in the county area and plans for out of county schools are being developed.

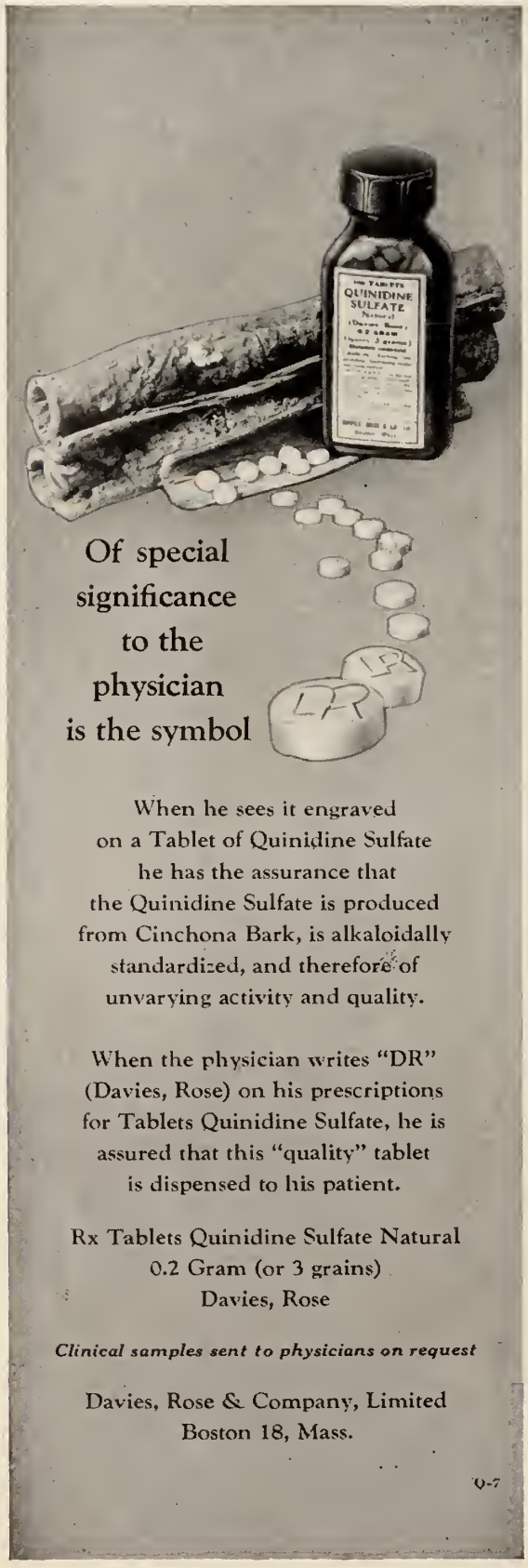
MSMS President C. I. Owen, M.D., has voiced his sincere approval of the Health Fair. Doctor Owen has declared:

> "The Kent Medical Foundation is to be commended for looking ahead with the wisdom shown in the development of the HEALTH FAIR. I am sure that in the years to come every individual connected with this extensive community educational and career orientation project will indeed look back with pride upon its accomplishments. I know of no better opportunity to encourage today's youth to pick a profession and plan with a purpose than through your HEALTH FAIR. I truly hope all teachers, parents and young people will take advantage of this rare experience."

The Michigan Health Council will hold its Annual State Conference during the same week—which, incidentally, is Michigan Week—to help emphasize the need for health personnel. Many members of the Michigan Health Council are actively engaged in assisting in the planning and arranging for exhibits and films, and in stimulating an interest in students to attend the Fair.

For additional information on "Health Fair" write: Joseph R. Lentini, M.D., Chairman, Health Fair, Kent Medical Foundation, 190 Monroe N.W., Grand Rapids 2, or phone 454-1817.





"Smoking and Health" Workshop Hears M.D.

An inter-agency meeting in Lansing on "Smoking and Health" was called recently by the Michigan Tuberculosis and Respiratory Disease Association.

Henry J. VandenBerg, Jr., M.D., Chairman, MSMS Cancer Control Committee, presented the opening address. According to Dr. VandenBerg, "Approximately one out of five teen-agers begin smoking in their freshman year in high school. By the time these same teen-agers have reached their senior year, one out of three are regular smokers."

The lack of real government leadership creates difficulties in organization for effective moves against smoking, Doctor VandenBerg noted. The Surgeon General of the U. S. feels that it is merely his position to inform, he said.

The principal causes of teen-age smoking, the speaker said, are (1) smoking in adults and siblings, (2) advertising of tobacco products, (3) the availability of tobacco products through coin vendors, and (4) emotional and psychological problems of teen-agers today.

Doctor VandenBerg noted that many parents who smoke and ask their children to refrain from smoking are unsuccessful, as the children ask, "Well you are smoking, why can't I.". A good answer to this, he pointed out, is for the parents to say to the child, "when I was young and started smoking over 20 years ago, the problem was new and the facts we have today were unknown. Now the facts are known. We know that smoking is definitely harmful, that it is a cause of lung cancer and respiratory diseases and may result in/or worsen respiratory diseases. Cigarette smoking is an addiction problem and you too will become addicted if you begin to smoke."

Other speakers representing The Michigan Division of the American Cancer Society, The Michigan Department of Health, The Michigan Department of Public Instruction, The Michigan Health Council and The Michigan Tuberculosis and Respiratory Disease Association.

The Inter-Agency meeting suggested these activities:

1. Set up a state conference of health and education leaders to discuss the facts regarding the harmful effects of smoking and to plan educational activities for schools. This may also be done on a regional and local level.

2. Develop a kit of materials on smoking to be

(Continued on Page 420)

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(equivalent to 2 cc. paregoric)

DOSAGE: Adults: Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

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"Smoking and Health" Workshop

(Continued from Page 418)

drawn from available and newly developed materials from the agencies concerned.

3. Organize an Inter-Agency Council to coordinate the efforts to be accomplished.

4. Hold a workshop for teachers of universities and high schools inviting science, home economics, health and physical education teachers, etc., to present to them facts about smoking and instruction in the possible methods for teaching the subject to their students.

5. That pilot demonstrations be set up within the Detroit school system and two other smaller communities. This pilot demonstration will test materials and methods for discouraging smoking among school age children.

The committee recommended another meeting of the interested agencies to review and make recommendations for beginning these pilot studies and for the formal development of an inter-agency council on cigarette smoking and health. Irvin Nichols, MTRDA Executive, was asked to continue as chairman pro tem.

Study Over-lapping Health Insurance Coverage

The Michigan Hospital Association Committee on Prepayment Plans, in cooperation with Blue Cross and the Michigan Committee of the Health Insurance Council, will conduct a study of the extent, amount, and implications of duplicate hospital insurance among hospital patients. Concern has been expressed that overlapping insurance coverage increases utilization, distorts national statistics on hospital expense, and complicated planning for hospital expansion. The study will attempt to develop a foundation of factual data for future consideration.

U-M Medical Alumni Newsletter Issued

The University of Michigan Medical Center Alumni Society has published its first alumni newsletter. The mailing went to about 10,000 U-M Medical School graduates, present and former University Hospital interns and residents, graduates of the U-M School of Nursing and other interested parties.

The four-page newsletter highlighted the Eighth Triennial Alumni Conference (held last November)

(Continued on Page 422)

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(Continued from Page 420)

and announced that the alumni conference will be held annually rather than every third year.

The 1963 reunion will be held October 18 and 19, known as "The Annual Conference of Alumni of the Michigan Medical Center."

Editor Heads Lansing MMS-MHS Member Council

The Lansing Blue Cross-Blue Shield Member Council has elected its second set of officers. They will serve for two years.

Chosen as chairman was Ink White, publisher of the Clinton County Republican News, St. Johns; serving as first vice-chairman is Frank Corser, international representative, United Auto Workers, AFL-CIO; as second vice-chairman is George Miller, president, Miller Dairy Farms, Eaton Rapids; and as secretary is Perry Katz, executive secretary, Lansing Community Services Council.

Six Doctors Assisted by Placement Service

Recent placements by the M.D. Placement Service of the Michigan Health Council have included the following: Conrado S. Topacio, M.D. (Buick Motor Company, Flint); Louis Charbonier, M.D. (Warren); Russell J. Wood, M.D. (Dundee); Rebilo A. Diccion, M.D. (Addison); Wilbur Haak, M.D. (Wyoming); and M. J. Lexmond, M.D. (Ishpeming).

Western Michigan GP Group Elects Officers

G. Edward Braunschneider, M.D., Grand Rapids, is the new president of the Western Michigan Academy of General Practice.

Dirk Mouw, M.D., Grand Rapids, recently was chosen president-elect. Other new officers are Jerome Manciewicz, M.D., Grand Rapids, vice-president; B. P. Kool, M.D., Grand Rapids, secretary-treasurer, and Arthur J. Tesseine, M.D., Grand Rapids, as a member of the board of directors.

Children's Hospital, WSU Symposium May 23-24

The Sixth Annual Clinic Days of Children's Hospital of Michigan and the Pediatric Department of Wayne State University College of Medicine will be held on May 23 and 24, at the headquarters of the Wayne County Medical Society. The topic for this year's symposium is "Applied Genetics in the Field of Pediatrics."

Further information may be obtained by writing to Mrs. Thelma Drake at Children's Hospital.



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Editorial Comment

Comments on Blue Cross-Blue Shield Hearings

NOTE: During the Blue Cross-Blue Shield hearings, many newspapers voiced editorial comments. Following are excerpts from four editorials.

(*Lapeer County Press*, February 1, 1963)

We think that Blue Cross is pretty much what its subscribers want it to be, even if they are loath to admit it.

Ever hear a not-very-sick person brag that he was going to the hospital because he'd been paying Blue Cross for a long time and "it's time I got something back"? This person is really boasting about robbing you. Do you accuse him, or do you agree that you'd do the same thing?

If the steady rise in Blue Cross rates is to be halted, it will take more than a few watchdog committees and magazine articles aimed at doctors and hospitals. It will take an aroused change in the attitude of the people who pay the $20-plus every month.

(*Detroit Free Press*, February 11, 1963)

There are, to be sure, suggestions for reducing costs that merit close scrutiny.

A suggestion that merits consideration is elimination of normal maternity benefits from the program.

Aside from a few suggestions such as these, there is little to recommend. The hard fact is that the cost of medical care is going up and will continue to go up.

Both Medicare and Kerr-Mills run into the same economic problems as the Blues. Somebody has to pay for better medical care, more extended coverage and the simple fact that we are living longer.

Improvements can be made in the program, certainly. But anyone who thinks that the rising cost trend can be reversed, or avoided by handing it over to the government, is living in an unreal world. It just doesn't work that way.

(*Detroit News*, February 12, 1963)

Cost and use of health care services have risen and will continue to rise. The Blues' income and outgo must balance, or they crack up. They are too important to be allowed to fail.

If every leak alleged by the detractors were to be found and plugged, Blue rates would still go up, because the cost of medical care—and its use—will continue to rise. The Blues' basic problem lies in their attempts to care for the very groups intemperate critics accuse them of mistreating: Low-income families and the aging.

Social Security medicare, as now outlined, is woefully inadequate. Blue contract benefits make it look sick. And when expanded—as inevitably it would be—to equal what the Blues in Michigan now offer, the cost would make Blue rates look miraculously cheap.

We suggest again that health care for the aging and low-income families can best be provided—best in terms of both cost and quality of care—by government subsidy for the purchase of health care contracts like those offered by the Blues.

Until that subsidy load is lifted from their backs, the Blues will continue to limp.

(*Grand Rapids Press*, February 12, 1963)

Two factors largely determine what Blue Cross' costs will be and what its rates therefore must be. One is hospital operating costs, and the other is the steady advance of medical science.

Hospital operating costs have been rising steadily, because both labor costs and the prices on almost everything hospitals buy have been going up. Labor costs are by far the more important because they represent about 70 per cent of a hospital's total operating costs.

The only obvious way to hold down hospital insurance costs without sacrificing the benefits of scientific program is to eliminate or curtail some of the services traditionally covered.

Hospital insurance rates can be held in check only by limiting services. But apparently no one wants to do that.

AIUM PROCEEDINGS AVAILABLE

Copies of the 96-page, illustrated book Scientific Proceedings of the Seventh Annual Conference of the AIUM are now available.

The scientific proceedings are papers delivered by doctors who reported their experiments and case histories in the use of ultrasonics at The American Institute of Ultrasonics in Medicine conference held on Aug. 25 last year in New York City.

For a copy of the proceedings, send 25c to cover costs of handling and mailing to The Birtcher Corporation, 4371 Valley Blvd., Los Angeles 32, California.

Brief and to the Point

ELECTED FELLOW—William Stapleton, Jr., M.D., Detroit, the MSMS Historian, has been elected a Fellow of the American Association for the Advancement of Science.

* * *

WRITERS ELECT—The Michigan chapter of the American Medical Writers Association recently elected C. Howard Ross, M.D., Ann Arbor, as president for 1963. Also chosen were Hazen Miller, M.D., Royal Oak, vice-chairman, and Charles W. Sellers, M.D., Detroit, secretary-treasurer.

* * *

ASIM SPEAKER—Richard C. Bates, M.D., Lansing, discussed the "Values of Solo Practice" during the seventh annual meeting of the American Society of Internal Medicine in Denver, Colo., March 29-31. The banquet speaker was William DeMougeot, Texas speech professor, who addressed the MSMS County Secretaries Public Relations Seminar in 1962.

* * *

ELECTED — Park W. Willis, III, M.D., Ann Arbor, was recently chosen as president-elect of the Michigan Heart Association. The outgoing president, Muir Clapper, M.D., Detroit, installed Sidney E. Chapin, M.D., Dearborn, as president for 1963.

* * *

IN VIETNAM—Lawrence A. Pratt, M.D., and his wife Alice E. Palmer, M.D., of Grosse Pointe, are serving in South Vietnam as staff members of the University of Saigon's Medical and Education Center. They both will help to staff and administer the new hospital, rebuilt largely with American funds.

* * *

CITED BY JCC— John C. Rawling, M.D., has been honored by the Flint Jaycees as the "Outstanding Young Man of the Year in Flint." Doctor Rawling was not able to accept the honor in person—as he was absent serving his second stretch on the SS HOPE. The award also recognized Doctor Rawling's work with Flint youth and welfare groups.

* * *

BACK HOME— Vlado Getting, M.D., Ann Arbor, recently made a two-week visit to military bases in Alaska as a consultant in preventive medicine for the Air Force Surgeon General.



JOINS STATE COMMISSION—Kenneth R. Magee, M.D., of Ann Arbor, recently was appointed by Governor Romney to the Michigan State Mental Health Commission. Doctor Magee, a University of Michigan neurologist and member of the Washtenaw County Board of Supervisors, succeeds Richard A. Cutler, M.D., a psychology professor at the University of Michigan.

Peter A. Martin, M.D., Detroit, psychiatrist, was appointed by Governor Romney as his personal special consultant in the mental health field.

* * *

BEGIN NEW BUILDING— Site-clearing has started for the new Lawrence D. Buhl Research Center for Human Genetics in the University of Michigan Medical Center. Completion of the three-level building is expected in the fall. The center was possible through a $250,000 gift from the Lawrence DeLong and Cora Peck Buhl Fund of Detroit and by a matching grant from the federal government.

* * *

HONORED NATIONALLY— Wm. S. McNary, president of Michigan Blue Cross, recently was selected to receive the American Hospital Association's 1963 Justin Ford Kimball Award. The Award, named for the founder of the Blue Cross movement, is presented annually for "outstanding encouragement given to the concept of prepaid voluntary health care plans." Mr. McNary will formally receive the Award at the American Hospital Association's Annual Meeting August 26-29 in New York City.

ON PROGRAM— The program for the Central Neuropsychiatric Hospital Association meeting in Chicago March 14-15 listed Ralph S. Green, of Rochester, as leader of a discussion on "Open Versus Closed Medical Staffs."

* * *

HONORED— Recently many friends honored Earl C. Potter, M.D., and his wife in L'Anse, before leaving to make their home in Sun City, Calif. Doctor Potter, a director of the National Board of Medical Examiners, formerly practiced in Lansing and came to Baraga County 10 years ago.

* * *

LEAVES AMA— C. Joseph Stetler, director of the American Medical Association's Legal and Socio-Economic Division and general counsel of the AMA, will become general manager and general counsel of the Pharmaceutical Manufacturers Association, effective July 1. Mr. Stetler, an attorney, has been a member of the AMA staff since 1951.

* * *

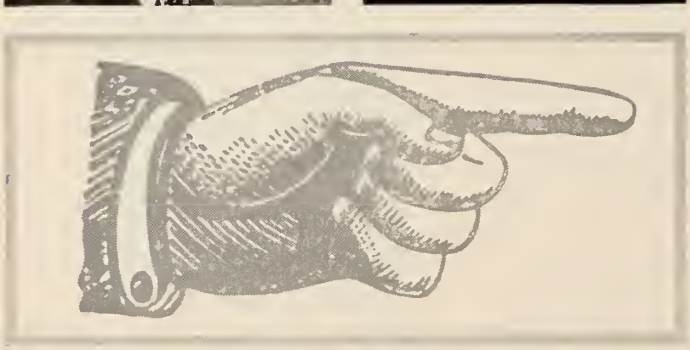
HONORED— Nelson Singer, M.D., East Detroit, recently received a certificate of appreciation and a 20-year pin for service to his area's Selective Service Board.

* * *

RETURNS— Ely W. Harelik, M.D., has returned to his former position as Medical Superintendent at the Detroit House of Correction.



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Michigan Authors

Guenter Corssen, M.D., Ann Arbor, "Changing Concepts of Pulmonary Atelectasis," *Journal of the American Medical Association*, February 2, 1963.

Charles G. Child, III, M.D., Ann Arbor, "Gastrointestinal, Biliary, and Pancreatic Conditions," *Surgery, Gynecology and Obstetrics*, February, 1963.

Sidney Friedlaender, M.D., and **Alex S. Friedlaender, M.D.,** Detroit, "Clinical Effects of Ragweed Antigen Emulsion," *The Journal of Allergy*, October, 1962.

G. D. Albers, M.D., Grand Rapids, "Branchial Anomalies," *The Journal of the American Medical Association*, February 9, 1963.

Martin J. Urist, M.D., South Haven, "Surgery in Horizontal Strabismus," *American Journal of Ophthalmology*, January, 1963.

T. P. Haynie, M.D., M. M. Nofal, M.D., and **W. H. Beierwaltes, M.D.,** Ann Arbor, "Treatment of Thyroid Carcinoma with I^{131}," *Journal of the American Medical Association*, February 2, 1963.

James M. Pierce, Jr., M.D., Esmond Braun, M.D., A. James Sniderman, and **Harvey Y. Lewis, M.D.,** Detroit, "The Concept of Resistance to Flow Applied to the Lower Urinary Tract," *Surgery, Gynecology and Obstetrics*, February, 1963.

Robert D. Burton, M.D., Grand Rapids, "Round Window Injury: Auditory Behavioral and Electrophysiological Consequences in the Cat," *Transactions of the American Academy of Ophthalmology and Otolaryngology*, Volume 66, No. 6, November-December, 1962.

Jack C. Westman, M.D., Ann Arbor, **Eugene W. Kansky, M.D.,** Palo Alto, **Mary E. Erikson, M.S.W.,** Ann Arbor, **Bettie Arthur, Ph.D.,** Ann Arbor, and **Ann L. Vroom, Ph.D.,** Strafford, Pa., "Parallel Group Psychotherapy With the Parents of Emotionally Disturbed Children," *The International Journal of Group Psychotherapy*, January, 1963.

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IN MEMORIAM

LLOYD A. DAVIS, M.D., 65, Camden physician since 1938, died February 13, 1963.

A graduate of Wayne State University College of Medicine, Doctor Davis was a past president of the Hillsdale County Medical Society, and a member of the American Academy of General Practice. He had been village president of Camden, and was a past member of the Camden school board.

WILKIE M. DRAKE, M.D., 87, Breckenridge general practitioner for 60 years, died February 11, 1963. He had practiced briefly in Detroit before coming to Breckenridge.

A graduate of the Detroit College of Medicine, Doctor Drake was a Life Member of the Michigan State Medical Society.

WALTER L. FINTON, M.D., 77, retired Jackson physician and surgeon, died February 14, 1963.

A 1907 graduate of the University of Michigan Medical School, Doctor Finton served his internship and was assistant surgeon at Northern Pacific Hospital, Brainerd, Minn., for two years before beginning his practice in Jackson in 1909. He retired from practice one year ago.

A Life Member of the Michigan State Medical Society, Doctor Finton was a past president and past secretary of the Jackson County Medical Society. He was a director of the Association of American Physicians and Surgeons, a fellow of the American College of Surgeons, and a staff member of Foote and Mercy hospitals in Jackson.

WILLIAM S. GONNE, M.D., 69, retired Detroit physician, died February 3, 1963.

A graduate of the University of Michigan Medical School, Doctor Gonne practiced in Detroit until his retirement a year ago.

He was a fellow of the American College of Surgeons and the American Academy of Ophthalmology and Otolaryngology. He was on the staff of Harper Hospital and was a former chief of staff for ear, nose and throat at Children's Hospital.

LEO A. GRAJEWSKI, M.D., 76, retired Detroit urologist, died January 26, 1963.

Doctor Grajewski, who had lived in Capac during his retirement years, was honorary chief of staff of Alexander Blain Hospital, Detroit.

A graduate of the University of Pittsburgh College of Medicine, he served his internship and residency at St. Mary's Hospital, after which he joined the staff at Blain Hospital.





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ACademy 7-1211

He was chief of staff at Blain from 1950 to 1960 and chief of urology from 1917.

He was a Fellow of the American College of Surgeons and the American Urological Association, a member of the Polish Medical Society, and a Life Member of the Michigan State Medical Society.

AUSTIN W. HEINE, M.D., 69, Mt. Clemens physician since 1932, died February 20, 1963.

Doctor Heine was a graduate of the University of Michigan Medical School in 1917. Following military service in World War I, he practiced in Detroit until he moved to Mt. Clemens in 1932.

He was a member of Phi Beta Pi Medical fraternity. He was a member of the Macomb County Board of Supervisors for many years and at one time served as acting mayor of Mt. Clemens.

RALPH S. JIROCH, M.D., 80, Saginaw physician for more than 50 years, died February 7, 1963.

A 1904 graduate of the Chicago Homeopathic Medical School, Doctor Jiroch was a past president of the Saginaw County Medical Society and a Life Member of the Michigan State Medical Society.

HIRAM NICHOLSON, III, 34, Detroit and Warren physician, died unexpectedly of a cerebral hemorrhage February 11, 1963.

A graduate of Wayne State University College of Medicine, he was assistant medical director in charge of resident and intern education of St. Joseph Mercy Hospital in Detroit and specialized in obstetrics and gynecology there. He was on the staffs of Holy Cross, East Side General, and Cottage Hospitals in Detroit.

He was a member of the Macomb County Medical Society, and a member of Phi Beta Tau medical fraternity.

NORMAN N. STEINBERG, M.D., 53, of Birmingham died February 26, 1963.

A 1935 graduate of the University of Michigan Medical School, Doctor Steinberg was a former chief of general practice at St. Joseph Mercy Hospital, Pontiac, and a past president of the American Neoplastic Society.

ANDREW L. SWINTON, M.D., 85, Marquette physician since 1918, died January 19, 1963.

A graduate of the University of Michigan Medical School in 1899, he did graduate work at University Hospital, followed by practice in Ontonagon from 1900 to 1918.

He was a Life Member of the Michigan State Medical Society.

Today two-thirds of those who now are admitted to mental hospitals are discharged the first year. But 30 years ago, a patient entering a mental hospital could expect to remain there up to 30 years or even the rest of his life.

Say you saw it in the Journal of the Michigan State Medical Society

Letters to the Editor

(Note: The following letter was received by Wm. Bromme, M.D., Detroit, coordinator for this special Cancer number.)

Dear Dr. Bromme:

Enclosed is a short manuscript that I promised I would write for you. As indicated in your letter, there is no bibliography and there probably isn't any necessity for one. I don't know whether illustrations are allowed, but I included one illustration which just came to light. It's the kind of thing that should be presented in all of the medical journals at the beginning of each campaign. Maybe it will help bring us back to a realization that all is not well in the cancer field.

Best wishes.

Sincerely yours,

Marshall Brucer, M.D.

Box 203, Route 4
Tucson, Arizona
and
Oak Ridge Institute of Nuclear Studies

Note: *Following is a letter from Robert F. Johnston, M. D., Eloise, in which he comments on a January* Journal *article by A. F. Boon, M. D., Ludington. Doctor Boon was then asked to respond, and that letter follows also.*

Dear Dr. Haughey:

I read with interest the article, "Severe bilateral monilial pneumonia in an adult treated successfully with amphotericin B," by A. F. Boon, M.D., which appeared in the January 1963 issue of the Journal. The diagnosis of moniliasis of the lung is an extremely difficult one and I don't think the problem has been clarified by Dr. Boon's article.

This problem was carefully reviewed by Baum, G. L., The Significance of Candida Albicans in Human Sputum, New Engl. J. Med. 263:70, 1960. Dr. Baum studied sputum specimens from 55 hospitalized patients, 34 hospital employees and 30 medical students for candida species. Fifty-five percent of the patients, 36% of the hospital employees and 20% of the medical students yielded sputum specimens positive for candida species. This confirmed previous studies which had demonstrated that Candida species are normal inhabitants of the mouth. (Knighton, H.T., Study of Monilial and other yeast like organisms found in oral cavity. J. Dent. Research 18:103, 1939.)

This information suggests that the Candida Albicans obtained from Dr. Boon's patient may well have been residing in the mouth. True, the cultures were obtained from bronchial washings, but as Dr. Baum states, "The use of the bronchoscope to collect specimens alters this situation only slightly because the bronchoscope must pass through the oral cavity to get into the tracheo-bronchial tree. Since the instrument frequently scrapes off small bits of pharyngeal mucosa, Candida organisms living on this mucosa are swept into the bronchoscope as well." Dr. Baum continues by stating, "Sputum cultures positive for Candida are poor evidence indeed for the presence of pulmonary Candidiasis. It is believed by Kligman (Kligman, A. M., Are fungus infections increasing as a result of antibiotic therapy? JAMA 149: 979, 1952) and in this laboratory, that the only way in which a diagnosis of pulmonary Candidiasis can be made is by demonstration of the organism histologically and culturally in a lung-biopsy specimen."

Because of this evidence, I cannot accept Dr. Boon's report as an example of an "established," "proven," "authenticated" case of monilial pneumonia. Nor can I condone his recommendation that amphotericin B, an extremely toxic agent, be used, when the evidence is so meager that the etiologic agent of the pneumonia is fungal. Certainly the fact the chest film cleared 30 days after initiation of amphotericin B therapy is only suggestive evidence that the agent was responsible. As indicated above, Candida is frequently found in the sputum and great care must be taken before attributing to this saprophyte an etiologic role in human disease.

Yours truly,

Robert F. Johnston, M.D.

Eloise, Michigan
February 11, 1963

Dear Dr. Haughey:

I have received your letter and a copy of Dr. R. Johnston's letter.

I would like to say that I am familiar with the references quoted by Dr. Johnston in his letter, especially that of Dr. G. L. Baum.

I think that it is entirely possible that monilial organisms may be passed into the bronchial tree by the bronchoscope. Bronchial washings should therefore grow the organisms. However, this possibility would not be so strong with a swab or a biopsy of a granulating area beyond the bronchoscope, which was also done in this patient.

There is also the possibility of contamination by surgical or laboratory personnel, 30% of whom also normally have monilial organisms in their mouth.

As to the lung biopsy specimen, this seems to me to be a radical diagnostic procedure best suited to a captive patient population which would not only be expensive, but in a critically ill patient, also dangerous. Also, the specimen could be contaminated by the surgical or laboratory personnel.

The response of the patient after a 15 day period was truly very dramatic. The x-ray evidence, bronchial washings, biopsies, physical examination, and response to treatment, leave me as certain now as I was then, that this is an established, proven, and authenticated case of monilial pneumonia.

Sincerely,

A. F. Boon, M.D.

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MALPRACTICE LAW DISSECTED FOR QUICK GRASPING. By Charles L. Cusumano, Member of New York Bar. New York 4, N. Y.: Medicine-Law Press, Inc. No price given.

A practical, readable primer for physicians by an experienced attorney. The emphasis is on relating legal principles to the day-to-day practice and problems of the physician. An understandable, survey treatment of a timely subject.

BOOKS RECEIVED

BIOCHEMISTRY. By Isreal S. Kleiner, Ph.D., Professor of Biochemistry, New York Medical College, Flower and Fifth Avenue Hospitals, New York, N. Y.; formerly Associate, the Rockefeller Institute for Medical Research, New York, N. Y., and James M. Orten, Ph.D., Professor of Physiological Chemistry, Wayne State University College of Medicine, Detroit, Michigan. 131 text illustrations and 5 color plates. Sixth edition. St. Louis: C. V. Mosby Company, 1962. Price, $9.75.

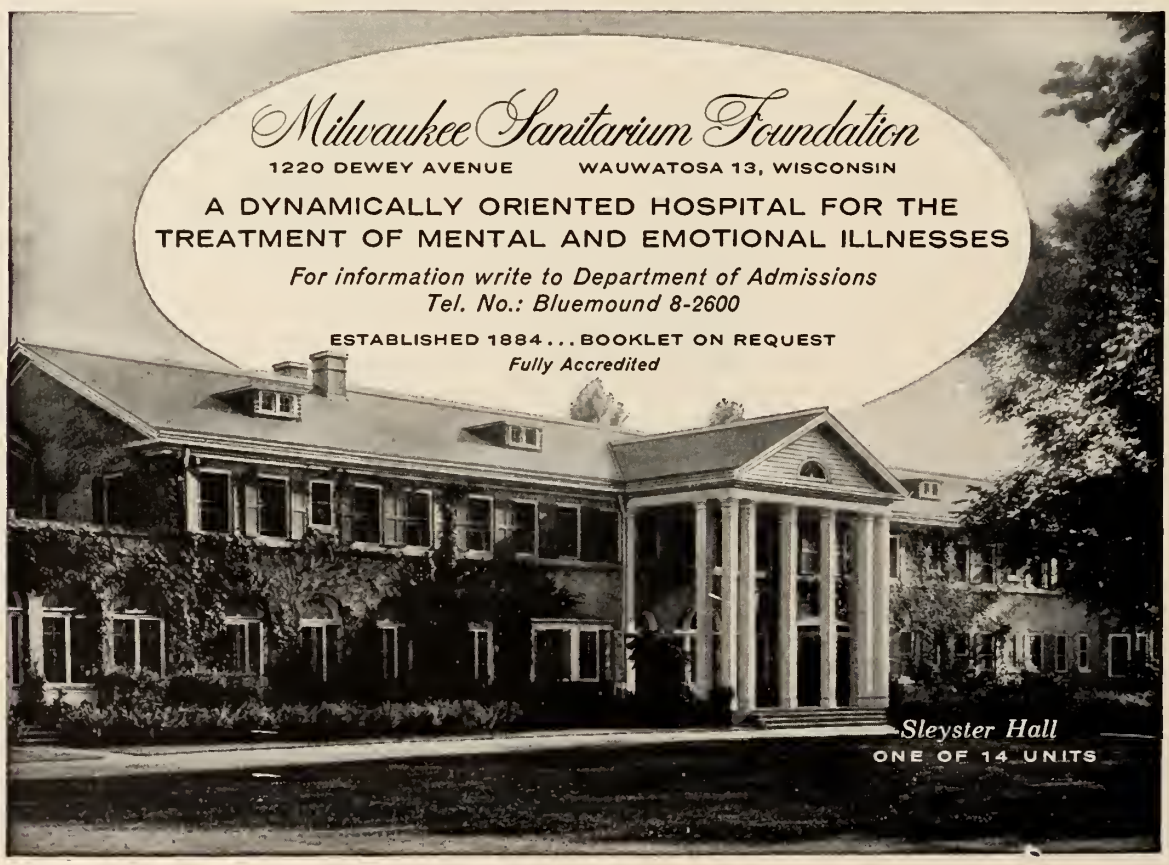
CONDITIONED REFLEXES. An Investigation of the Physiological Activity of the Cerebral Cortex. By I. P. Pavlov. Translated and edited by G. V. Anrep, M.D., D.Sc. 430 pages. 18 illus. New York, New York: Dover Publications, Inc. Price, Paper, $2.25.

MEDICAL GENETICS 1958-1960. An Annotated Review. By Victor A. McKusick, M.D., Professor of Medicine, The Johns Hopkins University School of Medicine, Baltimore, Md., and contributors. St. Louis: C. V. Mosby Company, 1961. Price, $14.50.

COMMON SENSE ABOUT PSYCHOANALYSIS. By Rudolph Wittenberg. Garden City, New York: Doubleday & Company, Inc., 1962. Price, $3.95.

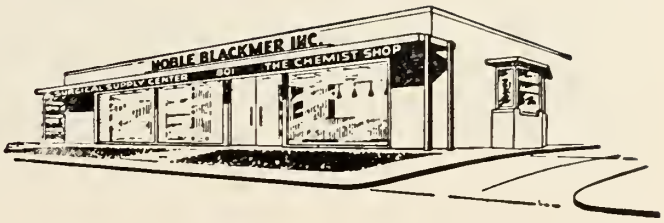
PSYCHOLOGY. Principles and Applications. By Marian East Madigan, Ph.D., Special Service Counselor, Division of Instruction, Milwaukee Institute of Technology, Milwaukee, Wisconsin; Consultant, Hospital Schools of Nursing, Milwaukee. Illustrated. Third edition. St. Louis: C. V. Mosby Company, 1962. Price, $5.50.

AN INTRODUCTION TO THE STUDY OF DISEASE. By William Boyd, M.D., Dipl. Psychiat., M.R.C.P. (Edin.), Hon. F.R.C.P. (Edin.), F.R.C.P. (Lond.), F.R.C.S. (Can.), F.R.S. (Can.) (Sask.). (Queens), D.Sc. (Man.), M.D. (Hon.) (Oslo), Professor Emeritus of Pathology, University of Toronto; Visiting Professor of Pathology, University of Alabama; formerly Professor of Pathology, University of Manitoba and University of British Columbia. Fifth edition, thoroughly revised. 174 illustrations and 4 colored plates. Philadelphia: Lea and Febiger, 1962. Price, $7.50.



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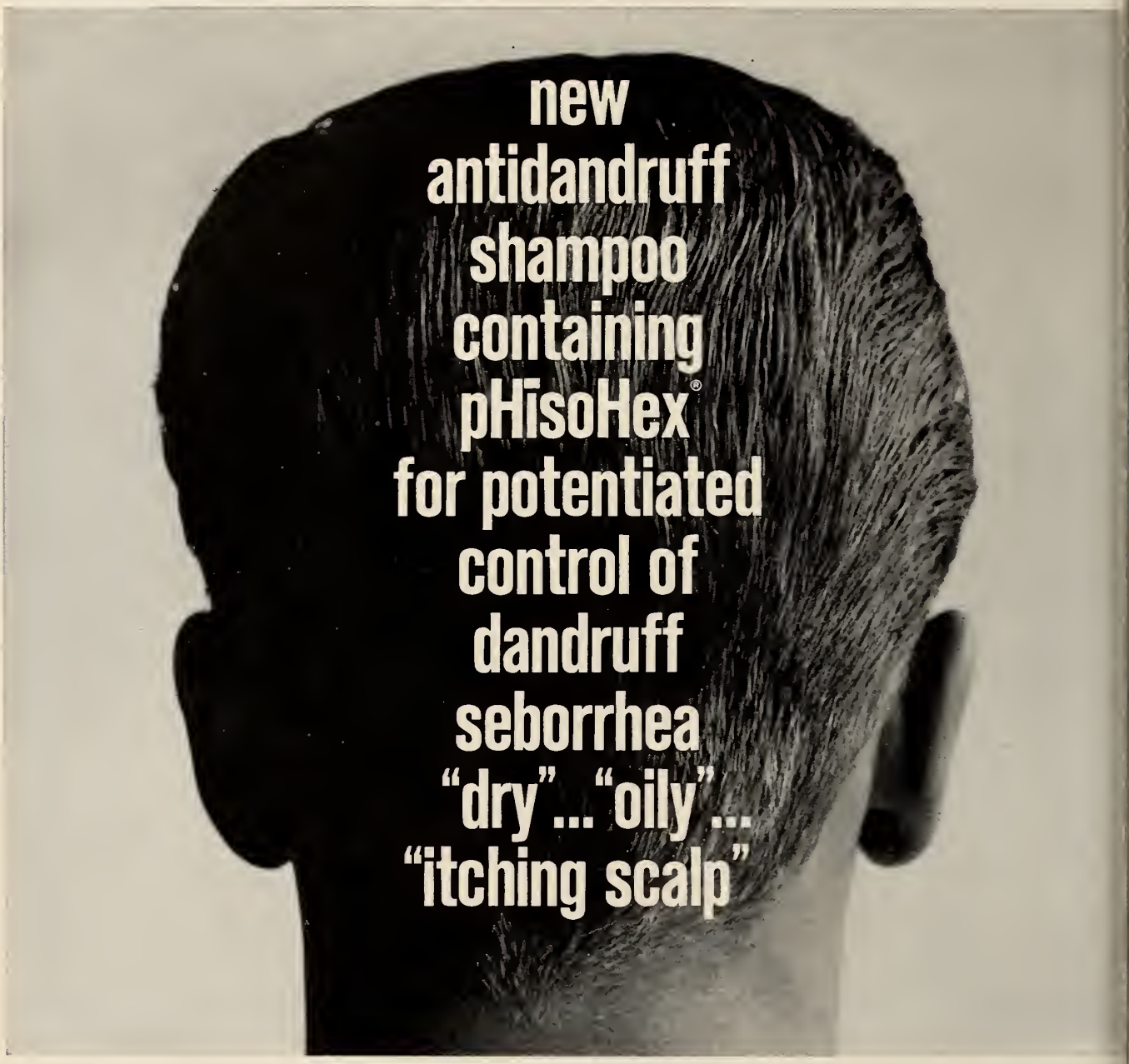
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Delegates

	Term Expires
J. R. Heidenreich, M.D., Daggett	1963
W. A. Hyland, M.D., *Chairman,* Grand Rapids	1963
O. J. Johnson, M.D., Bay City	1963
L. R. Leader, M.D., Birmingham	1963
C. I. Owen, M.D., Detroit	1964
G. W. Slagle, M.D., Battle Creek	1964
D. N. Sweeny, Jr., M.D., Detroit	1964

Alternates

	Term Expires
G. B. Saltonstall, M.D., Charlevoix	1963
J. M. Wellman, M.D., Lansing	1963
Sidney Adler, M.D., Detroit	1963
B. M. Harris, M.D., Ypsilanti	1963
R. E. Rice, M.D., Greenville	1964
A. Hazen Price, M.D., Detroit	1964
E. E. Martmer, M.D., Grosse Pte	1964

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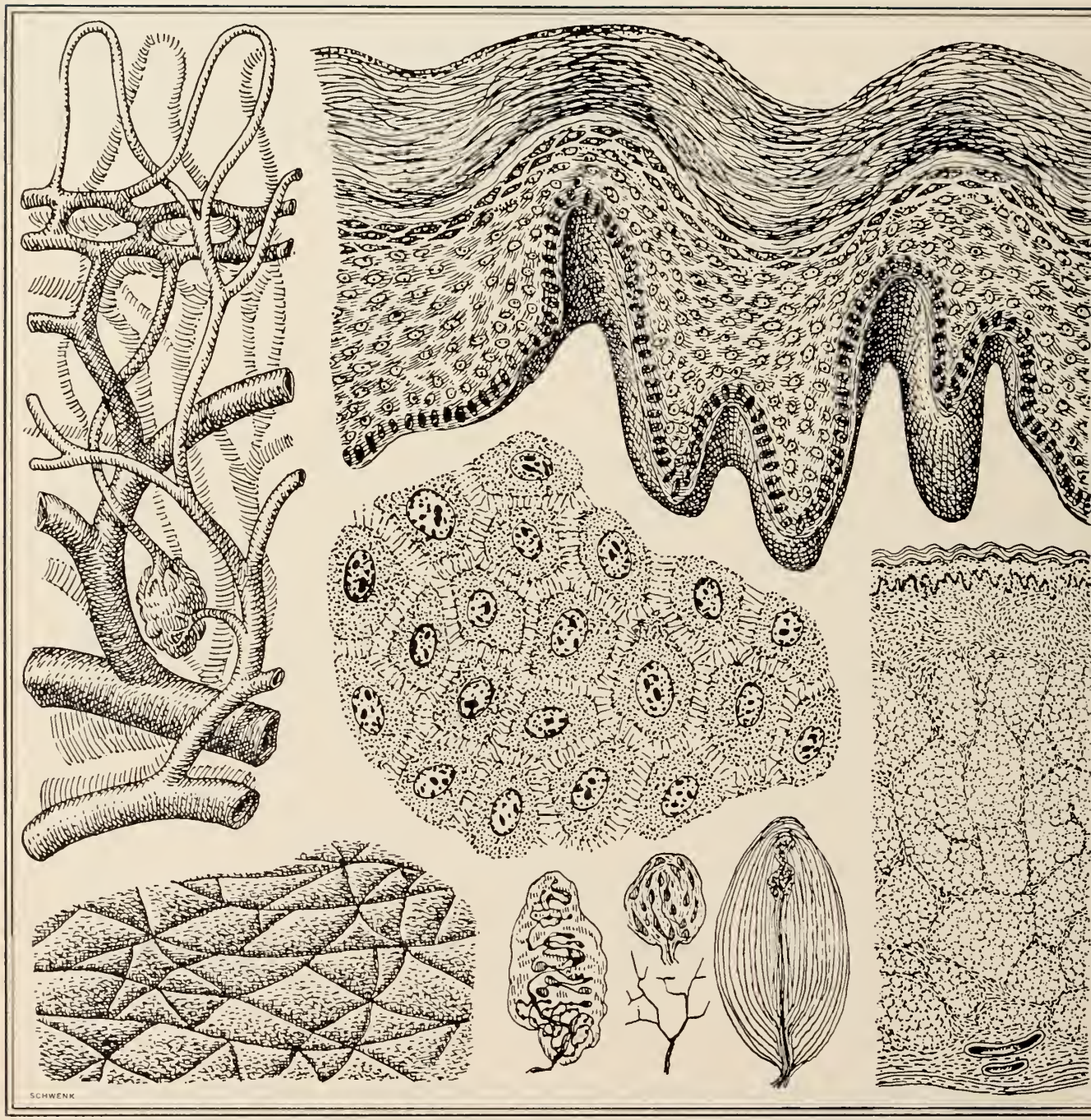
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President's Page

NO TIME TO RELAX



Clarence D. Owen

President

Michigan State Medical Society

This has been a busy spring for the many Michigan State Medical Society legislative workers. Our successes have been gratifying but we must not relax our efforts.

The MSMS Legal Affairs Committee assisted by the active legislative committees of the many component medical societies worked particularly hard and have been outstandingly successful.

First, we can justifiably take pride in the passage of the new State Constitution. Many MSMS members worked diligently in their own precincts and with various groups to point out the advantages of the new document. Leadership was shown by The MSMS Council which endorsed the new Constitution.

The State Legislature with some urging by our profession took action to pass the Good Samaritan Act; to provide for improvements in the Crippled and Afflicted Children's Acts; to give new rights to ringside physicians to stop fights during a round; to improve the machinery for fighting mental illness, etc. The results prove the MSMS proposals were valid and in the interest of the public.

Details about the spring legislative session will apear in the June issue of your MSMS Journal.

MSMS can also congratulate Alfred H. Whittaker, M.D., of Detroit, on his successful candidacy April 1 for the Wayne State University Board of Governors.

While we can be proud of our recent efforts, we cannot coast. Hearings are scheduled in July for Kennedy's King-Anderson scheme. Each member must become familiar with "HR 3920"—the number of the new bill—and be ready to help their fellow citizens and the Congressmen reach the right decisions.

Action in a true democracy has always come from the people—based on information and thoughtful evaluation. Your AMA, your state society and your component societies will provide the information and help with the evaluation process. You must do your own thinking; and then take action in concert.

Many MSMS Members Serve on AMA Committees



There are many MSMS members performing valuable service on the various committees and commissions of the American Medical Association.

An interesting report of the involvment of MSMS members in the AMA was presented at the March 15th meeting of The MSMS Council by William A. Hyland, M.D., Grand Rapids, MSMS Treasurer and Chairman of the Michigan delegation to the AMA House of Delegates.

The following Michigan doctors of medicine are serving now as Delegates to AMA—William A. Hyland, M.D., J. R. Heidenreich, M.D., Daggett; Orlen J. Johnson, M.D., Bay City; Luther R. Leader, M.D., Birmingham; Clarence I. Owen, M.D., Detroit; George W. Slagle, M.D., Battle Creek; D. N. Sweeney, Jr., M.D., Detroit.

The following are Alternate Delegates: Sidney Adler, M.D., Detroit; B. M. Harris, M.D., Ypsilanti; G. B. Saltonstall, M.D., Charlevoix; J. M. Wellman, M.D., Lansing; E. E. Martmer, M.D., Grosse Pointe, A. Hazen Price, M.D., Detroit; R. E. Rice, M. D., Greenville.

Serving on various AMA committees are the following: William Beierwaltes, M.D., Ann Arbor, Nuclear Medicine; Arthur Curtis, M.D., Residency Review for Dermatology; Russell N. DeJong, M.D., Ann Arbor, Residency Review for Psychiatry and Neurology; Harold Falls, M.D., Ann Arbor, Representing Ophthalmology on the Study of coordinate relationship of Medicine with Allied Professions; Albert E. Heustis, M.D., Lansing, Residency Review for Preventive Medicine; Leonard Himler, M.D., Ann Arbor, Joint Committees of the Councils, Chairman Committee on Mental Health in Industry; William A. Hyland, M.D., Grand Rapids, Constitution and Bylaws Committee Chairman, Communications Chairman.

Max Lichter, M.D., Melvindale, Council on National Security, Disaster Medical Care Chairman; Clarence Livingood, M.D., Detroit, Dermatology—Alternate Delegate of Section, Dermatology Committee, Archives of Dermatology, Residency Review for Dermatology; Lawrence Merle, M.D., Ann Arbor, Archives of Otolaryngology; Joseph G. Molner, M.D., Detroit, Medical Facilities; Clair Muir, M.D., Detroit, Section on Internal Medicine Secretary; Norman D. Nigro, M.D., Detroit, Standing Committee of Medical Education and Hospitals, and Residency Review for Colon and Rectal Surgery.

Robert L. Novy, M.D., Detroit, Insurance and Prepayment Plans—Standing Committee of Council on Medical Service, Council on Medical Service Appointees Ad Hoc Liaison Committee with Council on Medical Education and Hospitals, Liaison Committee of Council on Medical Education and Hospitals and Council on Medical Services, Operation of Joint Commission on Accreditation of Hospitals, Medical Insurance—Recent on Committee on Medical Practices; H. Marvin Pollard, M.D., Ann Arbor, Section on Gastroenterology and Proctol-

ogy; Bruce Proctor, M.D., Detroit, Associate Editor of Otolaryngology; James W. Raw, Jr., M.D., Ann Arbor, Residency Review for Physical Medicine; Henry Ransom, M.D., Ann Arbor, Archives of Surgery; Maurice Seevers, M.D., Ann Arbor, Council on Drugs.

George W. Slagle, M.D., Battle Creek, Insurance and Prepayment Plans—Standing Committee of Council on Medical Service, Medical Practices, Descriptive Coding on Medical Services Ad Hoc; Frederick Swartz, M.D., Lansing, Chairman Committee on Aging, Problems concerning Institutional Care of the Chronically Ill Aged; Wolf W. Zuelzer, M.D., Pleasant Ridge, Specialty Journals—Editorial Boards American Journal of Diseases of Children.

New MSMS Life Insurance Plan Offers Full Family Protection

Recently offered to the membership, the new MSMS Insurance Plan became effective February 1 with hundreds of doctors participating in the program. Total insurance volume for members and covered dependents is nearly 20 million dollars.

Term protection in amounts up to $30,000 is available. The insurance is renewable to age 70, and convertible without medical requirements at any time after the member's policy has been in force five years. Among other outstanding features in the plan is the option to include spouse and dependent children, ages six months to 23 years or prior marriage, each for $5,000, all in one policy. Children age 15 days to 6 months, if dependent coverage is in force, are covered for $1,000. Cost for full family coverage is exceedingly low. Significantly, two-thirds of the members participating in the plan elected to include their dependents.

Each member receives an individual policy. Initial amount of protection for the member, $10,000, $20,000, or $30,000, as selected, remains level throughout the life of the policy. The policy is convertible in the full amount as provided, and there is no reduction in this amount at advanced ages.

Mainly purchased for family security and to preserve estate values, cover last expenses, inheritance taxes, et cetera, the policy is also used to cover mortgage redemption, and other financial commitments and obligations which might otherwise seriously cripple the estate. Younger members find it prudent to purchase term protection as the means of providing the maximum insurance that their money will buy, and, it is pointed out by the administrators that the conversion feature provides an option to switch to a permanent insurance program which later can be handled more adequately. Conversion is not, however, mandatory. The provision does guarantee future insurability for the insured and his dependents, if covered.

Under the waiver of premium provision, if the insured member becomes permanently and totally disabled before his 60th birthday, not only are his premiums waived during the period of disability, but all premiums for covered dependents are likewise waived.

The MSMS plan is one of a very few of its kind available to members of professional societies throughout the nation. It is open to enrollment at any time (members under age 60 and in active practice) subject to a satisfactory health history acceptable to the underwriters, Continental Assurance Co., of Chicago. It is administered jointly by the Ben P. Stratton Agency, Lansing, and C. M. Verbiest and Associates, Inc., general agents, Detroit. Full information may be obtained from the Verbiest Agency, 2001 Woodward Ave., Detroit 26.

Health Council Urges Attendance, May 21-23

"Michigan, Health Capital of the World" is the theme for the annual meeting of the Michigan Health Council at the Pantlind Hotel, Grand Rapids, May 21-23.

The meeting will coincide with the Kent County Health Fair at the Civic Auditorium, May 19-25.

All MSMS members, wives, medical assistants, and friends are urged to particiate in both events.

Keynote speakers at the Health Council Conference will be John L. Norris, M.D., medical director of Kodak Park Works, Rochester, New York, about "Medical Aspects of Chronic Absenteeism;" and Ronald W. Lamont-Havers, M.D., medical director, Arthritis and Rheumatism Foundation, New York, on "Quackery in Arthritis."

The major topics for the three-day program cover:

"Student Health Day"—Tuesday, May 21

- Teen-agers and Cigarettes
- Continuous Health Supervision Program
- Pre-School Vision and Hearing Screening
- Effective School and Junior Health Councils

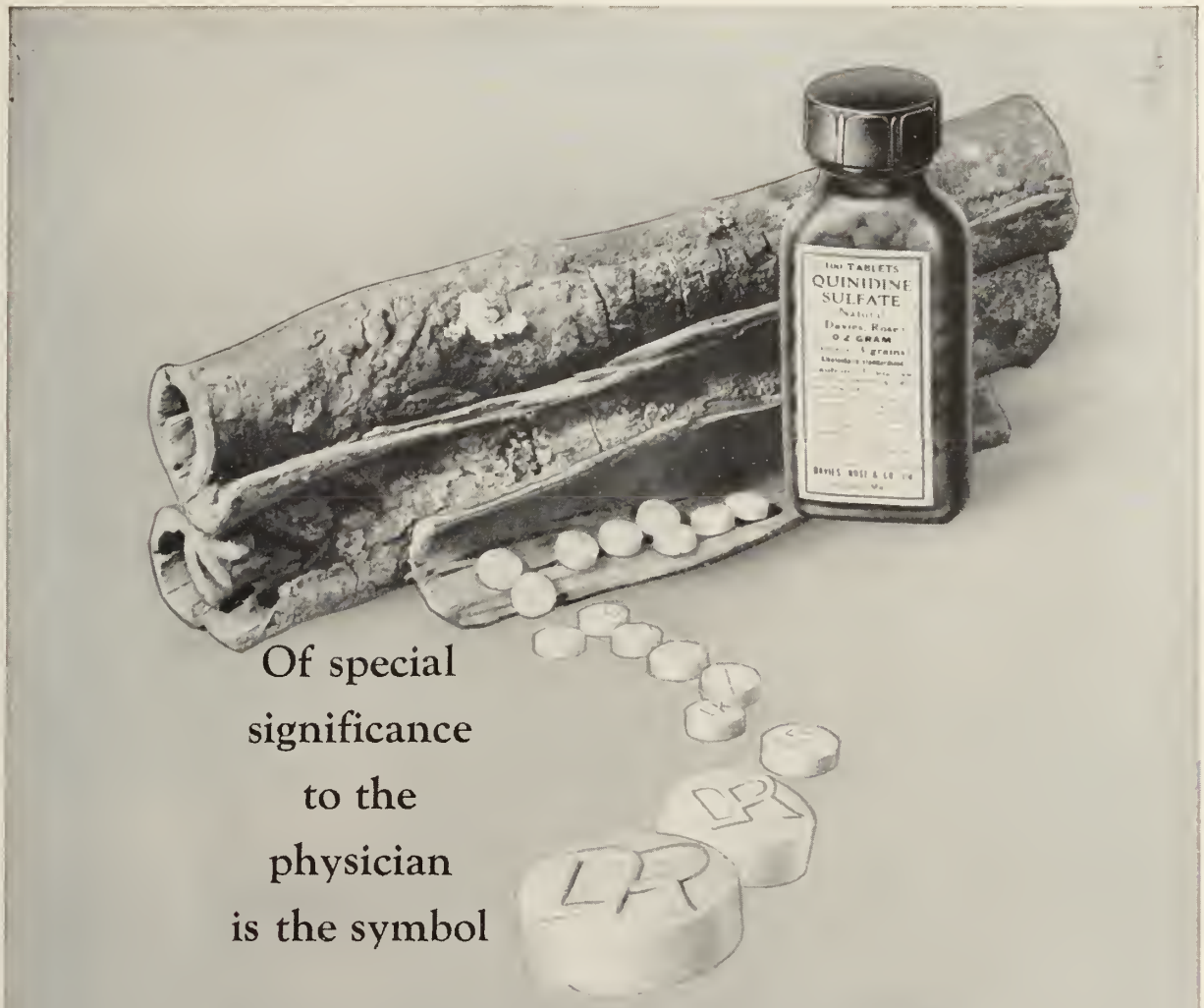
"Community Health Day"—Wednesday, May 22

- Medical and Economic Aspects of Chronic Absenteeism
- Coordinated Home Care Programs
- Obtaining Doctors for Communities
- Community Health Programs for the Elderly
- Health Manpower and Recruitment in Michigan

"Health Quackery Day"—Thursday, May 23

- Food Faddism and False Claims
- Health Frauds Affecting the Elderly
- Use and Abuse of X-rays
- Extent of Health Quackery in Michigan

(Turn to Page 448)



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ABOVE—MCI General Chairman George V. Slagle, M.D., center, Battle Creek; and Norman Harebottle, M.D., Fowlerville, left, learn about the television equipment in the hotel ballroom from Robert Reath, of Smith Kline & French, which presented the daily telecast from the University of Michigan Hospital.

1963 MCI

Photos from the outstanding 1963 Michigan Clinical Institute will appear also in the next several numbers of THE JOURNAL to vividly illustrate the excellent array of speakers and their enthusiastic reception by the attending doctors of medicine.

AT RIGHT—The MCI Clinical Round Tables drew interested doctors each morning. Leaders for this Cardiac session are: left to right, Vernon E. Wendth, M.D., Detroit; L. H. Birch, M.D., Grand Rapids, chairman; James R. Jude, M.D., Baltimore, Maryland; and Herbert E. Sloan, M.D., Ann Arbor.





ABOVE—The MSMS Exhibit, describing services to members, offered a silver dollar to doctors who could find their name in a single line of lettering. Here, Richard Rappaport, M.D., Flint, receives a dollar from E. R. Scott, right, MSMS field representative, while Alan Hodgins, Jr., left, medical student at University of Toronto, watches.

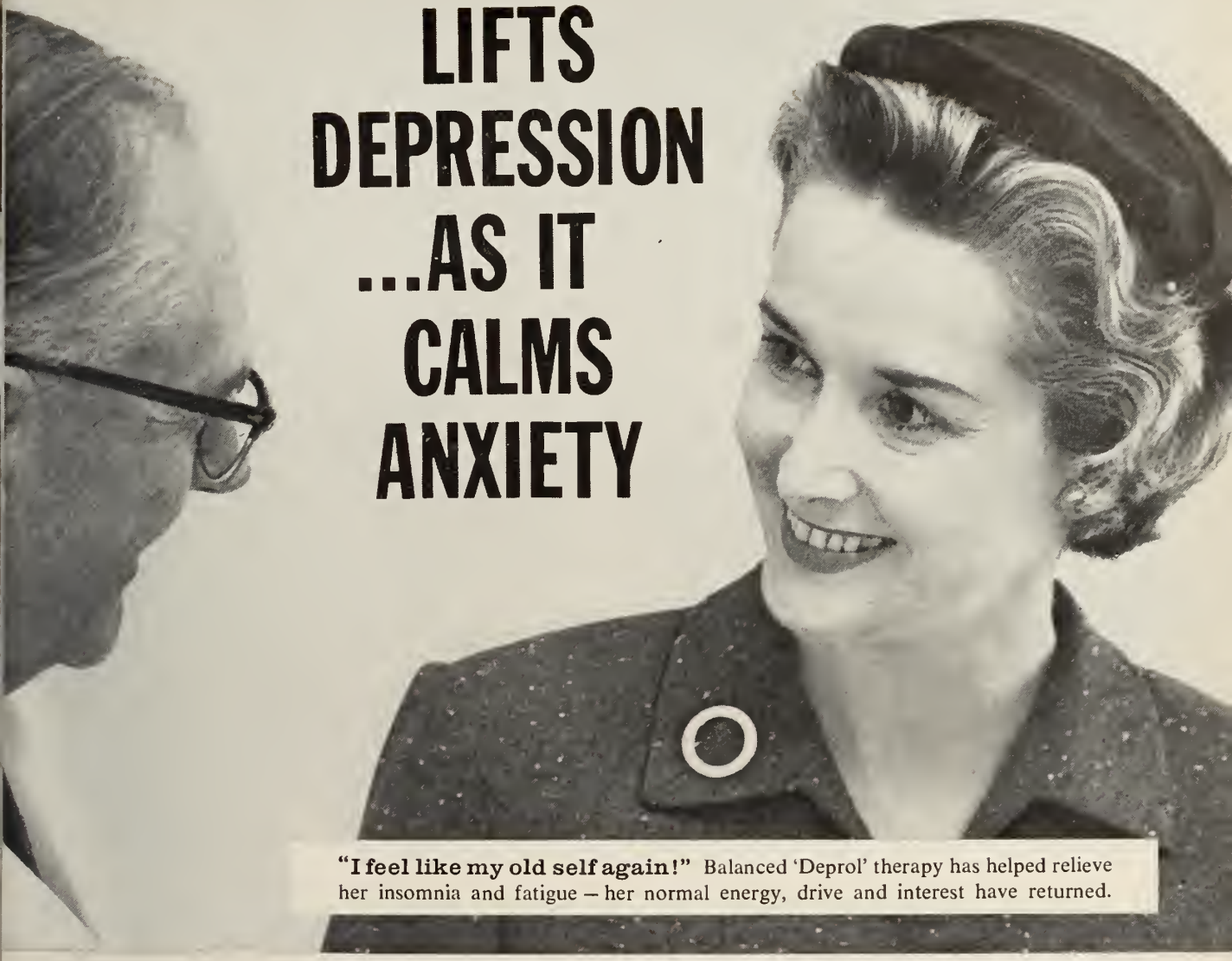




ABOVE—Enthusiasm was high at the Annual Conference for Residents, Interns, and Senior Medical Students. A panel discussion about Religion and Medicine included, left to right, R. E. L. Berry, M.D., Ann Arbor; Rev. Michael G. O'Leary, Detroit; F. L. Rapport, M.D., Flint, moderator; Rabbi Irwin Groner, Detroit; Rev. Franklin Bennett, Flint; and A. E. Hirschfeld, M.D., Detroit.

AT LEFT—Philip Thorek, M.D., Chicago, presented the annual Michigan Foundation for Medical and Health Education Lecture about "Intestinal Obstruction."

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1. Prescribing Supplements of Dietary Fluorides, Council of Dental Therapeutics, J.A.D.A., 56:591, April, 1958.
2. Fluoride Compounds, Accepted Dental Remedies, 27th Ed.:139, 1962.

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HIGHLIGHTS of The Council

Meeting of March 15, 1963

Sixty-seven items were discussed at the March meeting which immediately followed the Michigan Clinical Institute. Chief items of importance were:

- The proposed plan of the Office of Emergency Planning was presented by C. P. Anderson, M.D., Chairman of MSMS Disaster Medical Care Committee. The recommendations of the MSMS Committee will be circulated to all Council members for consideration at the May 15 meeting of The Council.
- Agreement for operation of the Michigan Diabetes Detection Program, as approved by the MSMS County Societies Committee, was recommended to The Council. The MSMS President was authorized to sign the agreement in behalf of MSMS.
- In executive session, The Council was presented with an up-to-date report on Michigan Medical Service by Sidney Adler, M.D., President. The Council encouraged Michigan Medical Service's President to call a meeting of members of the MMS corporate body to consider the serious problems that he described.

 The Council authorized Speaker J. J. Lightbody, M.D., to send a letter to seated Delegates of MSMS recommending that, when the meeting of the corporate body of MMS is called, prior to such meeting the Delegates meet in small groups similar to the Councilor District Conferences held annually prior to the MSMS House of Delegates meeting; further that each Councilor be requested to stimulate such a meeting in his Councilor District. The Council requested the Board of Michigan Medical Service to send members of the corporate body a history of the facts pertinent to the question of the rate increase prior to any meeting of the corporate body.

 In addition The Council approved the following statement:

 > The Council advises the corporate body of Michigan Medical Service that it should approach any meeting regarding the future of Michigan Medical Service with the end in view of restoring Blue Shield to continuing fiscal solvency and effective service to the public of Michigan in the philosophy inherent in the intent of its original *organization* and *operation*.

- Report on Michigan's representation in the House of Delegates, the councils and committees of the American Medical Association: Detailed report was presented by Wm. A. Hyland, M.D., of Grand Rapids, Chairman of the Michigan Delegation of the AMA. The report was approved with commendation and the recommendations in the report were endorsed.
- Committee Reports.

 (a) The Legal Affairs Committee, through Chairman Otto K. Engelke, M.D., reported on the new "Hometown Legislative Program" developed by the AMA for use by component societies, which plan was approved by The Council.

 (b) The Legal Affairs Committee (nucleus), meetings of February 21 and March 7 reporting on legislation were approved, with MSMS supporting in principle S. B. 1074 of the Michigan Legislature re a Michigan Mental Health Program.

 (c) Cancer Control Committee, meeting of January 10 reviewed method of reporting positive and negative smears, cytology booklet, Cancer Comment Page in JMSMS, recommendation that the Committee seek opportunities to present cancer lectures before statewide non-medical groups, work with and through Michigan Cancer Coordinating Committee, and desk reference cards on cancer; also discussed was a possible change in the Michigan law re designation of medical research projects.

 (d) Mental Health Committee, January 16, reviewed public meetings of the Mental Health Department, the Michigan mental health statutes, and the appointment of subcommittees to review same.

 (e) Mental Health Committee February 14. These minutes reviewed reports on mental health legislation, reports of Subcommittee on Community Health Services, of Subcommittee on Commitment Laws, and Subcommittee on Composition of the Mental Health Commission; also Interstate Compact for Mental Health.

 (f) Medical Socio-Economic Committee, January 30, reviewed Pilot Workshop in Oakland County and recommended additional workshops in three or four other areas of the State; also reported long-range planning activities of other AMA constituent societies.

 (g) Committee to Arrange 1963 Residents-Interns-Senior Medical Students Conference—meeting of February 7. These minutes outlined the program for the meeting to be held on Thursday, March 14, coincident with the Michigan Clinical Institute.

 (h) Cardiac Disease Control Committee, February 13, reviewed the relationship between Michigan Heart Association and the Rheumatic Fever

Control Program of the Cardiac Disease Control Committee and set guidelines for future activities of the Rheumatic Fever Control Program. The continuation of rheumatic fever diagnostic centers was discussed and report on cardiac disease services to the public was received; also desk reference cards including those proposed on coronary heart disease were considered.

(i) Committee to Survey Utilization of Health Insurance, February 13, outlined three possible approaches to continue the Committee's work, and reviewed plans for developing a program of study.

(j) Occupational Health Committee, February 26, reviewed a statement of policy re laboratory and x-ray procedures in connection with non-occupational cases, a statement of policy re tetanus immunization, the report of the subcommittee on workmen's compensation, report of Subcommittee on Medical Service in the Small Plant, and a report on component societies having occupational health committees.

The Council authorized the appointment of a special ad hoc committee to study and attempt to solve the problems outlined in the report of the Subcommittee on Workmen's Compensation.

(k) Special Committee on Alcoholism and Drug Addiction, February 27, reviewed progress on MSMS Journal articles re alcoholism, discussed paregoric legislation, reviewed activities in Michigan in the field of alcoholism education and treatment, and discussed possible projects and activities that county societies' committees might conduct on alcoholism.

(l) Public Health Committee, February 28, considered 1962 MSMS House of Delegates Resolutions Nos. 19, 8 and 60.

The Council commended the Public Health Committee for its detailed report but postponed consideration of the minutes until the May 15 meeting of The Council so that Oscar D. Stryker, M.D., the Chairman of the Public Health Committee might present the minutes in detail.

(m) Medical Care Insurance Committee, March 7, reviewed the MSMS Seminar of January 24 on "Community Relations", the AMA Prepayment Insurance Conference, 1962 House of Delegates Resolution No. 11, and discussion re Michigan Medical Service.

(n) Publication Committee, March 15, presented progress report on production of MSMS Journal, on Journal advertising, report of subcommittee re Journal content, and revision of mailing list of complimentary Journals.

The Council approved the Publication Committee report with commendation.

- Student Nurse Instruction in Basic Sciences. In accordance with instructions of 1962 House of Delegates, the MSMS views had been sent to appropriate groups including the Michigan State Nurses Association. A reply from the President of this Association expressed appreciation for MSMS concern for student nurses instruction but suggested a different course of action.

 The Council referred the correspondence to the Liaison Committee with Michigan State Nurses Association.

- The objections of the Michigan Pathological Society to the Michigan Department of Health's Study to Obtain Uterine Cancer Statistics on Female Relief Recipients was referred to the appropriate MSMS Committee.

- Religion and Medicine. The Reverend Doctor Paul McCleave, Director of the AMA Department of Religion and Medicine, had discussed with President C. I. Owen, and President-Elect O. J. Johnson, the AMA plans for cooperation with constituent societies to create the proper climate for communication between the physician and clergymen in order to lead to the most effective care and treatment of the patient.

 The Council authorized its Chairman to appoint an MSMS Committee on Religion and Medicine.

- Appointments. Harvey C. Hansen, M.D., Battle Creek, was appointed as a member of the Occupational Health Committee; C. I. Owen, M.D., Detroit, was appointed as MSMS representative to attend the Vermont State Medical Society meeting in May; Otto K. Engelke, M.D., and four staff members were authorized to attend the AMA National Legislative Conference, Chicago, in April; R. W. Teed, M.D., Ann Arbor, and K. W. Toothaker, M.D., Lansing, were reappointed as delegate and alternate delegate, respectively, to the Michigan Health Council for 1963; G. B. Saltonstall, M.D., Charlevoix, was reappointed as MSMS Representative to the Michigan Association of the Professions Board; 1963 House of Delegates News Committee: J. J. Lightbody, M.D., Chairman, Detroit; J. W. Rice, M.D., Jackson; C. Allen Payne, M.D., Grand Rapids; R. W. Teed, M.D., Ann Arbor; and James P. Muldoon, M.D., Grand Rapids, Chairman of Scientific Exhibits Committee for 1963 MSMS Annual Session.

- Social Security Poll. Speaker J. J. Lightbody read the official notarized report from a Lansing service bureau which stated that out of a total of 4,964 cards tabulated, 3,099 MSMS members answered "yes" for Social Security; 1,845 answered "no"; and 20 expressed no opinion.

- Medical Aid to the Aged. Problems in the administration of the MAA program, especially in Wayne County, were discussed. The Council decided to

(Turn to Page 456)





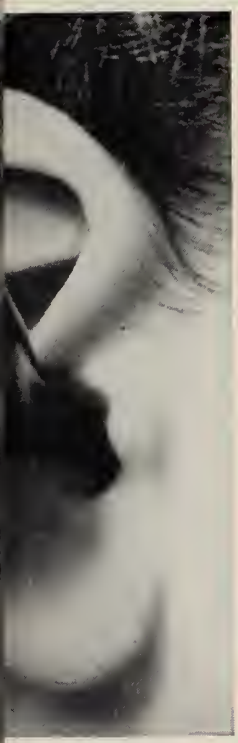


all things considered...the decision is for

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dose, thus helps protect against relapse—an "extra dimension" in broad-spectrum control.

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. *Side Effects* typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction.

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Syrup, 75 mg. demethylchlortetracycline/5 cc. and *Pediatric Drops*, 60 mg./cc.

Average Daily Dosage—Infants and Children: 3 to 6 mg. per lb. body weight, in 2 or 4 doses.

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Highlights of The Council Meeting

(Continued from Page 453)

petition the Michigan Social Welfare Commission (a) to rescind that portion of its administrative rule which pertains to implementation of medical aid to the aged which now reads: "The rate of reimbursement for services paid for by the County Welfare Board under the Act should not exceed the Board's rate for similar services in other cases"; (b) to issue a new ruling which in essence would provide for the reimbursement to hospitals and physicians for services to persons eligible under provision of this Act, at the same rates as provided by full audited hospital costs and the 1959 Michigan Uniform Fee Schedule for Governmental Welfare Agencies; and (c) that copies of this resolution be sent to the appropriate persons in the Legislature and in the state administration.

- Report of Ninth Annual Conference of Mental Health Representatives of State Medical Associations, drafted by MSMS Representative Benjamin Jeffries, Detroit, was presented, approved with thanks and referred to the MSMS Mental Health Committee.
- Report on Annual Congress of AMA Council on Medical Education and Hospitals, as presented by MSMS Representative J. W. Rice, Jackson, was considered and, because of its importance, deferred for further study at the May 15 Council meeting.
- Report on Third National Congress on Voluntary Health Insurance and Prepayment Plans, as reported by MSMS Represenative L. F. Hayes, Gaylord, was accepted with thanks, and referred to the Medical Care Insurance Committee.
- Activity of Staff. Executive Director Wm. J. Burns reported that the staff had attended 14 staff meetings since The Council's last meeting, had covered 16 committee meetings, 11 State Society nights, and had made 43 trips in all parts of the State doing liaison work with component societies. He also reported that the successful 1963 Michigan Clinical Institute registered 1,985 persons, including 1,084 MDs. A report on the new MSMS Research Department showed it was busy handling requests for data, doing continuous research for some six MSMS committees, conducting medical socio-economic workshops throughout the State, and preparing economic data cards for the Wayne County Speakers Bureau. The Department devoted much time in preparing an economic work-up for MSMS participation in the Blue Cross-Blue Shield hearings.
- Legal Counsel Lester P. Dodd presented opinions on (a) dispensing of drugs by MDs; (b) 1963 special assessment of MSMS; (c) admission to hospital (every patient admitted for services to be performed by a member of one of the allied health professions must not only be admitted by a staff physician but the staff physician must take the history, do a physical examination and be responsible for the patient's medical care throughout his stay); (d) hospital staff privileges for other than MDs; and (e) death certificates (the Michigan law does not require a specific pronouncement or declaration of death but does require the attending physician to sign a death certificate after satisfying himself of the fact). Legal Counsel also counseled with and advised members of a component society with respect to problems arising in their local hospital as a result of the adoption by hospital administrators of rules arbitrarily governing staff privileges; he also counseled with and advised a component society with respect to the propriety and legality of their medical staff going on record as disapproving a combined staff in their local community hospital.
- Public Relations Counsel H. W. Brenneman's report reviewed recent federal and state legislation of interest to the medical profession, publicity in connection with the 1963 Michigan Clinical Institute, a report on television and radio activities throughout the State, and meetings recently addressed by the Public Relations Counsel.

M.D. Speakers Talk To Detroit Area Clubs

One of the many activities connected with the Michigan Clinical Institute is the opportunity to provide speakers about medical matters to various organizations in the metropolitan area.

The following speaking engagements are reported by the MSMS office in Detroit:

J. J. Lightbody, M.D., Detroit, to Senior Citizen's Club of Lincoln Branch Library, about "Arthritis."

K. L. Krabbenhoft, M.D., Detroit, to Kappa Psi Pharmaceutical Fraternity, about "Nuclear Medicine."

C. E. Schorer, M.D., Detroit, to Vortex Club, about "Hypnotism—Uses and Abuses."

Stanley Olejniczak, M.D., Eloise, to Excalibur Club, about "Oh, My Aching Back."

A. Jackson Day, M.D., Detroit, to U and I Club, about "Prepaid Health Plans."

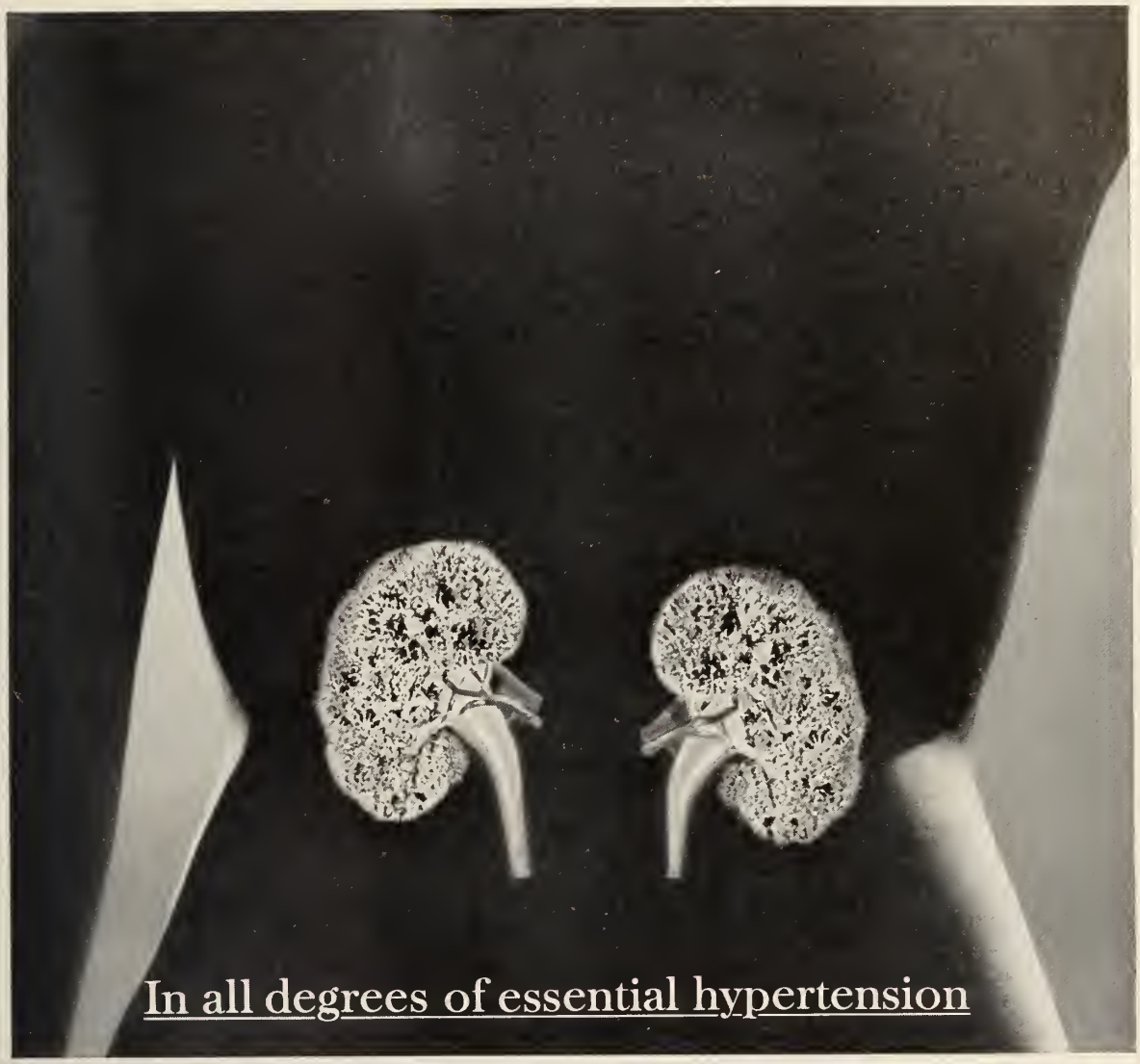
Charles Bower, M.D., Pontiac, to Kiwanis Club of West Pontiac, about "Hobbies and Health."

John G. Slevin, M.D., Detroit, to U and I Club, about "Socialized Medicine."

John R. Caldwell, M.D., Detroit, to Exchange Club, about "Heart Attacks—What and Why?"

Ralph A. Johnson, M.D., Detroit, to Queen Vestri Chapter--Order Eastern Star, about "Heart Diseases."

(Turn to Page 458)



Protect the kidneys and other threatened organs with Rautrax-N

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When treatment of hypertension is effective, the danger of damage to the renal system is reduced.[1,2] "Hypertensive patients suffer from vascular deterioration roughly proportional to the severity of the hypertension. ...Reduction of blood pressure to normotensive levels reduces or arrests the progress of vascular damage with a resultant decrease in morbidity and mortality. Among two comparable groups of patients with [nonmalignant] hypertension of equal severity, 72 per cent of those treated were still living after five years or more, while only 24 per cent of those not treated were alive at the end of this period."[1] *Because Rautrax-N lowers blood pressure so effectively, it will provide this important protection for your hypertensive patients.*

Rautrax-N—a combination of Raudixin, Squibb Standardized Rauwolfia Serpentina Whole Root, and the diuretic, Naturetin, Squibb Bendroflumethiazide—is effective in mild,[4] moderate[3,4] or severe hypertension.[3,5] It lowers blood pressure gently and gradually. And control of hypertension helps protect not only the kidneys but also the heart and brain from vascular damage.[2] For full information, see your Squibb Product Reference or Product Brief.

Supply: Rautrax-N—capsule-shaped tablets providing 50 mg. Raudixin, 4 mg. Naturetin, and 400 mg. potassium chloride. *Rautrax-N Modified*—capsule-shaped tablets providing 50 mg. Raudixin, 2 mg. Naturetin, and 400 mg. potassium chloride.

References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (4) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (5) Feldman, L. H.: North Carolina M. J. *23*:248 (June) 1962.

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(Continued from Page 456)

MSMS Maternal Conference Near Battle Creek, May 23-24

A review of "Perinatal Mortality Studies on a National Scale" by J. F. Donnelly, M.D., of North Carolina, will open the MSMS "Conference on Maternal and Perinatal Welfare" at Gull Lake, May 23-24.

A maximum attendance of 100 Michigan doctors is expected for this second conference at the MSU Conference Center, near Battle Creek.

Outstanding Michigan doctors of medicine and other leaders in these fields have been selected for the conference "faculty." Joining to present the program are the MSMS Committee on Maternal Health and the Michigan Department of Health.

Michigan Medical Meetings

Kent County Health Fair, May 19-25, Civic Auditorium, Grand Rapids.

Michigan Health Council State Conference, May 21-24, Pantlind Hotel, Grand Rapids.

Michigan Kidney Disease Foundation, May 25-26, Ann Arbor.

Maternal and Perinatal Welfare Seminar, May 23-24, Gull Lake. Write W. W. Jack, M.D., Box 152, East Lansing.

Upper Peninsula Medical Society, June 28-29, Sault Ste. Marie.

Coller-Penberthy Clinic, July 25-26, Traverse City.

Michigan State Medical Society Annual Session, September 25-27, Grand Rapids.

Midwest Regional Group of Medical Library Association, October 3-5, Bronson Hospital, Kalamazoo.

Hospital Section of Michigan Library Association, October 18, Bancroft Hotel, Saginaw.

Alumni Conference Michigan Medical Center, October 18-19, Ann Arbor.

What They Said About MCI

I enjoyed my participation in the Michigan Clinical Institute and certainly appreciated all the courtesy shown me there. I am sure that your Clinical Institute was a great success from what I saw of it.

J. R. Jude, M.D., Baltimore, Md.

* * *

I should like to express my appreciation to the Institute for the privilege of having addressed the meeting in Detroit. I was very much impressed with the graciousness of Detroit hospitality.

D. A. Dreiling, M.D., New York City

* * *

I greatly enjoyed the MCI meeting and hope I added a little something to its success.

Theodore G. Klumpp, M.D., New York City



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Demetrois Capetanakis, M.D.
3613 Devonshire
Detroit 24, Michigan
Thoracic Surgery
Peter J. Connaughton, M.D.
Burns Clinic
Petoskey, Michigan
Samuel R. Dismond, M.D.
1002 S. Saginaw St.
Flint, Michigan
General Practice
William R. Fellows, M.D.
22161 W. Outer Drive
Dearborn, Michigan
Jack A. Fiebing, M.D.
P.O. Box 283
Traverse City, Michigan
Anesthesiology
Roger C. Fulmer, M.D.
Burns Clinic
Petoskey, Michigan

Erwin Gutowitz, M.D.
420 S. Ballenger Hwy.
Flint, Michigan
Internal Medicine
John W. Hollis, M.D.
Fisher Body Division
Grand Blanc, Michigan
William H. Kaufman, M.D.
10149 Michigan Avenue
Dearborn, Michigan
Gary H. Knapp, M.D.
23611 Goddard
Taylor, Michigan
General Practice
William E. Macksood, M.D.
3169 W. Pierson Rd.
Flint, Michigan
Surgery
Harry Manuel, M.D.
Ypsilanti Medical Center
Ypsilanti, Michigan
John A. McColl, M.D.
1631 Gull Rd.
Kalamazoo, Michigan
William L. McCullough, M.D.
Burns Clinic
Petoskey, Michigan

A. F. Phillips, M.D.
X-ray Dept.
Hurley Hospital
Flint, Michigan
Roentgenology-Radiology
Dwight H. Porter, Jr., M.D.
3919 John R. Street
Detroit 1, Michigan
Dermatology
Gerald W. Powley, M.D.
1711 Merrill Street
Kalamazoo, Michigan
Massoud Razi, M.D.
18145 Mack
Detroit 24, Michigan
Surgery
Joseph C. Schaefer, M.D.
Burns Clinic
Petoskey, Michigan
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long term response . . . "Secondary failure is unlikely to occur" with phenformin[4] (DBI-TD capsules, DBI tablets). Phenformin has been successfully administered daily in diabetics in one study for over 3 years[2] and in another for up to 4½ years[1] with "a virtual absence of acquired resistance or true secondary failure."[1] Indeed, DBI has produced a satisfactory response in 55 to 60% of tolbutamide secondary failures.[3,7]

long term clinical safety . . . No liver or parenchymal organ toxicity has been observed after up to 2½ years of daily use of DBI-TD — nearly 5 years with the DBI tablets.[1,2,9] "The absence of hypoglycemic reactions" with phenformin "has been conspicuous."[5]

long term tolerance . . . DBI-TD is well tolerated with minimal g.i. side effects.[2,6,8] Radding et al.[6] report, "the relative freedom from gastrointestinal side effects was particularly reassuring . . . and in no instance was it necessary to discontinue the drug."

long term convenience . . . Once a day dosage — or at most twice a day — for great majority of diabetics makes DBI-TD simple and convenient therapy. Each dose lowers blood sugar gradually, smoothly, for about 12 to 14 hours.[6]

DBI-TD (brand of Phenformin HCl — N^1-β-phenethylbiguanide HCl) available as 50 mg. timed-disintegration capsules; bottles of 100 and 1000 capsules. Also available as DBI tablets, 25 mg., bottles of 100 and 1000.

Important: Before prescribing DBI-TD, the physician should be thoroughly familiar with directions for use, including indications, dosage, possible side effects, precautions and contraindications. Write for complete literature.

1. Pomeranze, J.: Clinical Med. 8:1155, June 1961. 2. Krall, L. P. and Bradley, R. F.: Geriatrics 17:337, May 1962. 3. DeLawter, D. E. et al.: J.A.M.A. 171:1786, Nov. 28, 1959. 4. Perkin, F. S.: J.A.M.A. 173:36, May 7, 1960. 5. Pearlman, W.: Phenformin Symposium, Houston, Feb. 1959. 6. Radding, R. S. et al.: Metabolism 11:404, April 1962. 7. Gold, A. et al.: Applied Therapeutics 2:137, 1960. 8. Brown, G. D. and Gabert, H.: Applied Therapeutics 4:451, May 1962. 9. Gold, A.: Applied Therapeutics 4:466, May 1962.

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Say you saw it in the Journal of the Michigan State Medical Society

Ingham Society, MSMS Provide First Aid



A first aid room is being operated in the Capitol Building to serve Legislators. This project is a joint effort of the Ingham County Medical Society and the Michigan State Medical Society.

This service is being provided to the State Legislature for the first time. It is operated much the same as the first aid station which was made available to Delegates during the Constitutional Convention.

D. Bonta Hiscoe, M.D., and Harry George, M.D., both of Lansing, were in charge of setting up the room. A telephone in the room provides communication between the nurse, any of the doctors on call, and the Society answering service.

Many letters of appreciation have been received from the legislators.

Ingham doctors participating in the activity are Doctors M. S. Sharp, J. L. Sheets, John Wellman, H. W. Harris, Oliver McGillicuddy, Robert F. Thimmig, James Wainright, K. S. Feeney, F. M. Dunn, Richard Pomeroy, Calvin Blair, F. W. Tamblyn, Robert Trimby, Kenneth Johnson, Robert C. Fune, H. J. Prall, Paul Larkey, Louis Harrington and J. M. Cook.

The room is staffed by Mary Ellen LePage, R.N.

The first aid station operated by the Ingham County Medical Society and MSMS is a real service to Michigan lawmakers. Here, Nurse Mary Ellen LePage, R.N., checks the blood pressure for Rep. Andrew W. Cobb, of Elsie, while, at left, is Rep. Donald M. Wismer, Jr., of Port Huron.





Photomotograph

A five-minute test with the Burdick Photomotograph indicates the patient whose record is shown above is hypothyroid. The entire procedure for this reliable diagnostic test for thyroid dysfunction — *positioning the patient, connecting the photomotograph to the electrocardiograph, tapping the Achilles tendon, checking the results* — takes but a few minutes, and the record is available for immediate diagnosis and permanent filing.

This simple yet reliable test should be as much a part of the complete physical as an ECG. Write us for full information.

Kupperman et al have reported the photomotogram test is unaffected by most of the conditions which invalidate other diagnostic procedures as a measure of thyroid dysfunction. Ask us for a complete reprint of this authoritative article—without cost or obligation.

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Legislators Address Ionia-Montcalm Society

Members of the Ionia-Montcalm County Medical Society, at a recent meeting, heard from their three Michigan legislators who gave progress reports on various bills and issues that they face in Lansing.

Participating were Senator Emil Lockwood and Representatives Lloyd Gibbs and Fred O. Olsen. Robert Rice, M.D., presided for the special Legislative program.

Expectant Parents Courses Approved by Jackson Society

The Jackson County Medical Society continues to provide "Expectant Parents' Classes" at Jackson in cooperation with the Jackson Public Health Department and the Jackson Public Schools' Adult Education Department.

The courses are held throughout the year, the sequence beginning in January, March and October.

The course, approved by the County Medical Society, covers such topics as Human Growth and Development, Health Habits, Feeding, After-Care and others.

Urges Use of Radio

If your county medical society is not utilizing the facilities of its local radio stations to their fullest extent, it's passing up a golden public relations opportunity, according to Robert E. Heerens, M.D., chairman of the Illinois State Medical Society audio-visual subcommittee.

"A recent ISMS survey indicates that medical programs are in great demand by radio stations," Dr. Heerens said, "and they can use all the medical news, interviews and public service 'spots' available."

Health Record

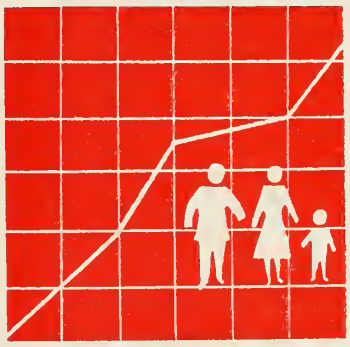
A recommendation that families keep a medical record on all members of the family comes from the American Medical Association. It should include, says the AMA, dates and findings of physical examinations, a list of serious illnesses, dates and reasons for stays in hospitals, and dates of all vaccinations. The record should note any known allergies or sensitivities to drugs. Some people, for instance, react violently to penicillin.

Say you saw it in the Journal of the Michigan State Medical Society

About Physician Distribution In Michigan, and Nation

By Richard M. Campau
MSMS Research Director

SOCIO ECONOMICS 463



The key person in the provision of health service is the physician. The most common measure in discussing adequacy of physician manpower is the physician-population ratio, that is, the number of physicians per 100,000 people in the general population. The physician-population ratio is often criticized as being inadequate as a measure of adequacy of physician supply, however, it is recognized by most authorities as the best tool now available.

The present situation in the United States, as described in the February, 1963, issue of *U. S. News and World Report*, is as follows:

(Quoting Dr. Luther L. Terry, U. S. Surgeon General)

"Over the past 10 years the output of our medical schools has lagged behind population growth. The physician-population ratio (137 physicians for every 100,000 people) has stayed almost constant only because foreign-trained physicians have filled such a large part of the gap between population growth and . . . medical school output."

Dr. Terry noted that adequate medical care takes about one physician for every 1,000 people. Yet in 1960, more than two thirds of 3,101 counties in the U. S. had only one physician for every 2,000 or more, he reported.

The shortage of physicians is most acute in rural areas, Dr. Terry emphasized. But even large cities are feeling the scarcity of M.D.'s in the less well-paying fields of medicine—particularly general practice.

The Federal Government has concluded that U. S. medical schools have got to be turning out at least 11,000 new physicians a year by 1973 to keep pace with the expected population growth. That would require, according to Government figures, a 50 per cent increase in graduating classes within the next 10 years. The equivalent of some 35 new medical schools would have to be built, staffed, equipped and put into operation within a period of 72 months to achieve this goal.

The present situation regarding number of physicians in the various Michigan Counties can be seen in the report of the Michigan State Board of Registration in Medicine, as of February 15, 1963, in adjoining column.

The future of medical education here in Michigan was recently investigated by the Ad Hoc Committee on Medical Education of the Michigan Coordinating Council for Public Higher Education. Here are their recommendations:

1. The capital construction program at The University of Michigan accepted in 1951 when the medical school class was increased to 200 (and the classes in dentistry and nursing enlarged) should be authorized and funded at the earliest opportunity.

2. The capital construction program for increasing the medical school class at Wayne State University to 200 should be authorized and funded at the earliest opportunity.

3. No later than 1967, appropriations should be made to expand medical education in Michigan so that by 1971, 100 additional first-year students would be admitted. It is recommended that to achieve this goal a new four-year medical school for 100 medical students be

established, the first class to enter in September, 1971.

4. A cooperative program of graduate education in the basic medical sciences between Michigan State University, The University of Michigan and Wayne State University is recommended, in which the present education resources of the three Universities would be strengthened and unnecessary duplication avoided.

A two-year program of graduate study in human biology would be established at Michigan State University leading toward either a Ph.D. or an M.D. degree. The course work in Anatomy, Physiology, Biochemistry, Bacteriology and General Pathology would be provided at Michigan State University and would be designed to be equivalent to similar courses in the medical schools of The University of Michigan and Wayne State University.

Specialized medical course work in Human Pathology, Pharmacology, Clinical Laboratory Diagnosis, Physical Diagnosis and the Introduction to Clinical Medicine would be provided by the Medical Schools of The University of Michigan and Wayne State University. Common criteria of admission and student evaluation would be adopted by the three Universities.

For those students seeking a Ph.D. degree, the entire program would be available at Michigan State University. Those students seeking an M.D. degree would transfer to The University of Michigan or Wayne State University for approximately the terminal semester of the two-year program. At the conclusion of the two-year program these latter students would be eligible for admission to the final years of medical school—either within or outside of the State of Michigan.

It is recommended that a joint committee representing the participating Universities be authorized to develop a definite plan for the establishment and operation of this cooperative program.

5. As soon as possible, and no later than 1964, a committee should be appointed to recommend on the location and sponsorship of the new four-year medical school. This committee should include representation similar to that of the present ad hoc committee, but in addition should have representatives from outside the State of Michigan experienced in medical education and particularly the development of medical schools.

This committee should make its report no later than 1964 and funds for planning as well as the appointment of a dean and a few core faculty members should be appropriated no later than 1966. Construction funds should be appropriated no later than 1968 in order that classes may begin in 1971.

6. It is of paramount importance that new obligations for expanding the base of medical education in Michigan should be undertaken only when the new program does not threaten availability of funds for established programs. The essence of timing will be to spread the capital costs so that the development of one program does not jeopardize another.

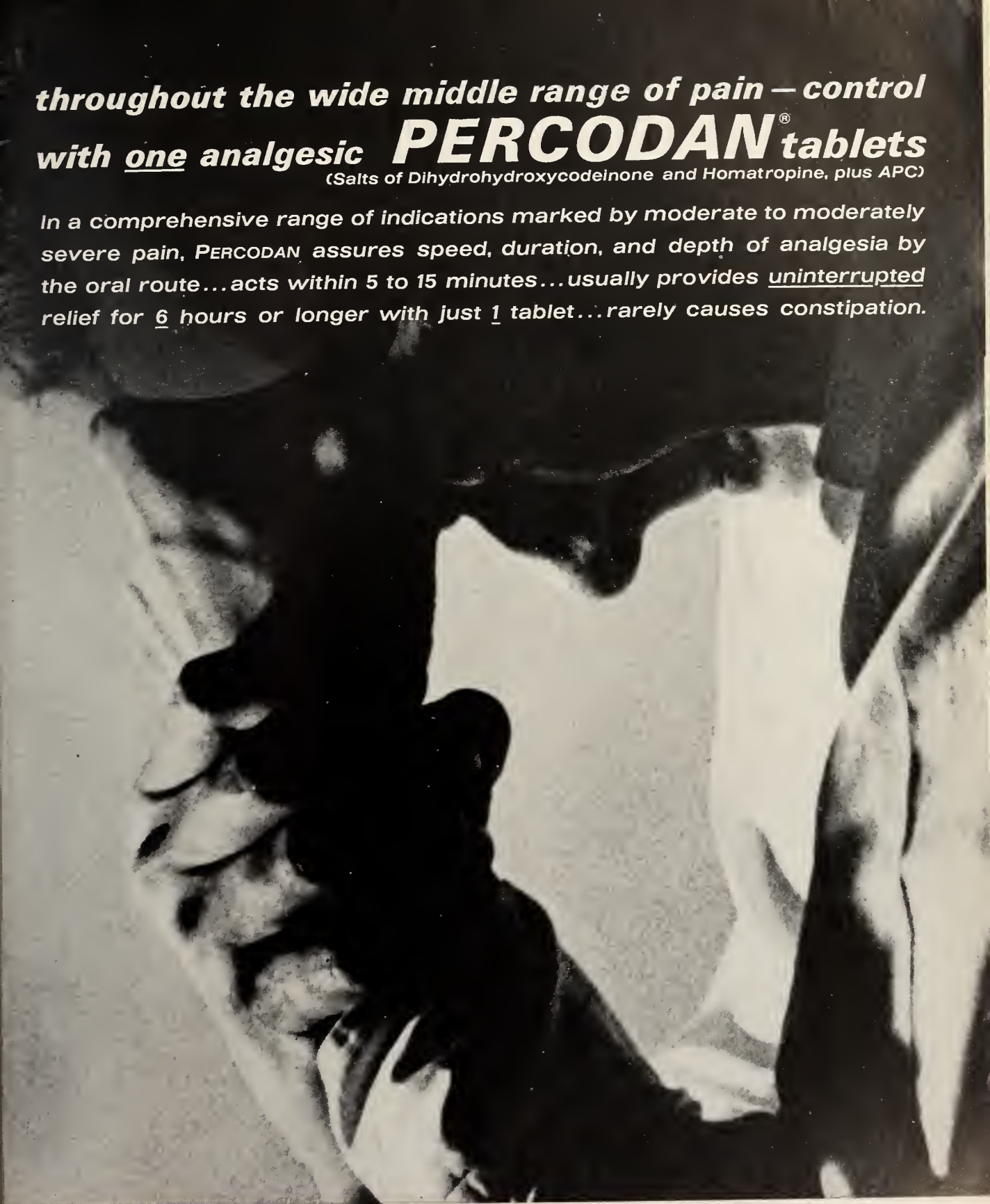
County by County Distribution of M.D.s

COUNTY	1960 POPULATION	M.D.s Registered 1961	1962	1963
Alcona	6,352	—	—	1
Alger	9 250	4	7	5
Allegan	57,729	26	27	21
Alpena	28,556	28	25	21
Antrim	10,373	3	4	4
Arenac	9,860	—	—	1
Baraga	7,151	1	2	1
Barry	31 738	18	20	16
Bay	107,042	89	91	86
Benzie	7,834	2	2	6
Berrien	149 865	108	109	109
Branch	34,903	24	26	30
Calhoun	138,858	129	133	135
Cass	36,932	11	11	12
Charlevoix	13,421	9	12	11
Cheboygan	14 550	7	7	7
Chippewa	32,655	19	18	19
Clare	11,647	5	5	4
Clinton	37 969	16	17	17
Crawford	4,971	5	5	5
Delta	34,298	21	23	25
Dickinson	23,917	21	24	27
Eaton	49,684	22	22	19
Emmet	15 504	27	29	30
Genesee	374,313	309	323	321
Gladwin	10 769	5	5	5
Gogebic	24,370	16	15	13
Grand Traverse	33,490	77	72	66
Gratiot	37,012	22	23	23
Hillsdale	34,742	16	17	17
Houghton	35,654	23	24	21
Huron	34 006	18	18	16
Ingham	211,296	248	254	246
Ionia	43,132	25	26	25
Iosco	16,505	2	3	5
Iron	17,184	13	14	11
Isabella	35,348	26	25	25
Jackson	131.994	127	125	128
Kalamazoo	169 712	199	209	216
Kalkaska	4,382	1	2	2
Kent	363,187	427	448	433
Keweenaw	2,417	2	—	—
Lake	5,338	1	2	2
Lapeer	41,926	26	25	24
Leelanau	9.321	—	—	1
Lenawee	77,789	57	54	55
Livingston	38,233	22	21	27
Luce	7,827	14	14	19
Mackinac	10,853	8	7	7
Macomb	405,804	98	102	154
Manistee	19,042	14	14	15
Marquette	56,154	48	48	45
Mason	21,929	18	17	17
Mecosta	21,051	10	12	10
Menominee	24,685	16	15	12
Midland	51,450	42	45	53
Missaukee	6,784	3	3	2
Monroe	101,120	42	41	43
Montcalm	35,795	22	21	23
Montmorency	4,424	1	1	1
Muskegon	149,943	118	116	124
Newaygo	24,160	19	17	18
Oakland	690,259	486	541	667
Oceana	16,547	8	9	9
Ogemaw	9,680	6	6	7
Ontonagon	10,584	5	6	7
Osceola	13.595	5	5	4
Oscoda	3,447	1	4	3
Otsego	7,545	8	9	9
Ottawa	98,719	61	67	73
Presque Isle	13,117	1	2	2
Roscommon	7,200	4	5	5
Saginaw	190,752	153	162	168
Sanilac	32 314	16	16	15
Schoolcraft	8,953	4	4	5
Shiawassee	53.446	33	34	33
St. Clair	107,201	69	69	72
St. Joseph	42,332	35	31	31
Tuscola	43,305	18	20	22
Van Buren	48,395	29	29	32
Washtenaw	172,440	591	621	642
Wayne	2,666,297	3,155	3,263	3,083
Wexford	18,466	13	14	20
	SUB TOTAL	7,431	7,714	7,746
OUT OF STATE		1,185	2,142	2 092
	TOTALS	8,616	9,856	9,838
MILITARY			277 (exempt)	399

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(Continued from Page 464)

One Per Cent in Texas Survey Need or Want $$$ for Care

Of 745,000 Texans aged 65 or older, one per cent need or want financial help for medical care, according to results of a survey released by Blue Cross and Blue Shield of Texas.

The survey bases its findings on information that shows that:

30 per cent of those over 65 are on Old Age Assistance and automatically have Blue Cross coverage as part of their benefits;

38 per cent have at least one health insurance policy;

5 per cent have sufficient incomes;

7 per cent are helped financially by their families;

5 per cent could receive help from their children if needed;

6 per cent believe that the aged should take care of themselves;

2 per cent had less than $100 in medical expenses in 1961.

The survey found that almost half (46 per cent) of all aged Texans have health insurance, sufficient savings or sufficient income, singly or in combination, to take care of their medical needs.

Six of 10 aged persons reported they were getting along financially about the same, or better, than at the age of 60. The survey found that 99 per cent had some source of income and 38 per cent were still working.

Twenty-three per cent were reportedly "doing without things, but most of these mentioned things that do not pertain to medical care." Three per cent said they went without medicine; four per cent said they went without medical care by a doctor, and one per cent said they went without surgery.

This Senior Group Opposes 'Medicare'

United Senior Citizens, Inc., has been formed by a group of elder citizens opposed to the passage of King-Anderson type legislation. The group has published a 34-page booklet entitled "STOP, THIEF!" which points out the dangers of "medicare" and the economic consequences of this type legislation. "STOP, THIEF!" may be obtained by writing the United Senior Citizens, Inc., 570 Fifth Avenue, New York 36, N. Y.

Incomes of State Residents Rise Slower Than in Nation

Personal income of all Michigan residents is likely to total $19.7 billion in 1963, a 2.4 per cent increase over 1962. This compares with a 4 per cent rise forecast for the United States.

The long term decline in Michigan's share of total U. S. income appears to be abating with the 1962 estimate of 4.40 per cent, and the 1963 forecast of 4.36 per cent.

A moderate gain of 1.3 per cent is now forecast in private wages and salaries. The percentage gains forecast for property income (5 per cent) and transfer payments (7.4 per cent) are also slightly above earlier expectations.

More Retirees Can Retain Health Insurance Protection

The Health Insurance Institute reports that four of every five employees covered under group health insurance policies issued by insurance companies last year have the right to retain their health coverage when they retire. In previous years, the proportion had been two out of every three.

More workers now will retain their group health insurance coverage upon retiring in two ways: by converting the group coverage to an individual policy, or by continuing the coverage on a group basis.

The Institute findings are based on data from 44 insurance companies which were responsible for nearly 75 per cent of total number of health insurance premiums written in 1961.

Helps Hospital Managers

A new program for reviewing and evaluating the business management of hospitals has been undertaken by the American Hospital Association. Standards of business management have been established and a system set up for evaluating an individual hospital's management procedures.

The standards, based on generally accepted management systems, policies and procedures, grow out of five years of work by the AHA's Hospital Counseling Program.

Nicely Said

The Washington Report (newsletter of the Chamber of Commerce of the United States) makes sense with its statement about the Medicare issue. In its recent publication forecasting the issues to be faced by the 88th Congress, the publication made this observation:

Compulsory health care for the aged—The Chamber of Commerce is in favor of adequate medical care for all Americans regardless of age. But we believe that the particular needs of the elderly are now being taken care of through private insurance plans and the Kerr-Mills Act, which aids the medically indigent. A legislative panacea, raising your Social Security taxes, is just not needed.

Question:

"What is a tranquilaxant?"

Answer:

"A drug that is both a tranquilizer and a muscle relaxant."

TRANCOPAL®
brand of
chlormezanone
is a tranquilaxant

As a tranquilizer, TRANCOPAL (chlormezanone/Winthrop) "is effective in the symptomatic treatment of anxiety."[1] Its tranquilizing properties are similar to those of other mild tranquilizers.[1] Furthermore, it relieves tension of both mind and muscle without interfering with normal activity or alertness.

The muscle relaxant properties[2] of this drug provide an extra dimension of effectiveness...relaxing the spasm which so frequently accompanies psychogenic disorders. Hence, the total therapeutic effect of TRANCOPAL (chlormezanone/Winthrop)—a true "tranquilaxant"—is to produce a relaxed mind in a relaxed body.

Unsurpassed Tolerance: Less than 3 per cent of patients develop side effects with TRANCOPAL (chlormezanone/Winthrop), such as occasional drowsiness, dizziness, flushing, nausea, depression, weakness and drug rash. If severe, medication should be discontinued. In most patients, however, side effects are minor and do not necessitate interruption of treatment. There are no known contraindications.

Available: 200 mg. Caplets® (green colored, scored), 100 mg. Caplets (peach colored, scored), each in bottles of 100.

Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; in some patients 100 mg. three or four times daily suffices. Children (5 to 12 years), from 50 to 100 mg. three or four times daily.

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References: 1. A.M.A. Council on Drugs: J.A.M.A. 183:469 (Feb. 9) 1963. 2. Gruenberg, F.: Curr. Ther. Res. 2:1 (Jan.) 1960.

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Get your low-back patient back to work in days instead of weeks

You can expect rapid results from 'Soma' (carisoprodol)—because this unique drug breaks up both the spasm and pain of low-back syndrome at the same time.

Your patients will usually begin to feel better within a few hours. And as Kestler demonstrated in a controlled study of 212 consecutive patients with low-back problems: the average time for full recovery was only 11.5 days with 'Soma' (carisoprodol), 41 days without it. (J.A.M.A., April, 1960.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely.

USUAL DOSAGE: ONE 350 MG. TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

Soma®
carisoprodol

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from the feet up—clears ringworm economically with half the dosage

Schering

fulvicin-u/f®

griseofulvin, ultra/fine, Schering

"Culture negative" after four weeks in this case of plantar tinea pedis

R. B., a 36-year-old writer, was first seen on November 5, 1962, with severe inflammatory tinea pedis involving the sole of the right foot. There was an 8-centimeter area of erythema, with vesicles, bullae and scales on the plantar surface of the foot. The lesion had been present for two weeks. Microscopic examination of scrapings showed hyphae, and cultures grew out *T. mentagrophytes.*

The patient was started on 0.5 gm. FULVICIN-U/F (griseofulvin, *ultra-fine*) daily. Three weeks later there was distinct improvement with only mild erythema and scaling present. After one additional week, therapy was discontinued and a second culture was negative. The patient was last seen on December 24, approximately three weeks after termination of therapy. At this time the skin was entirely normal in appearance.







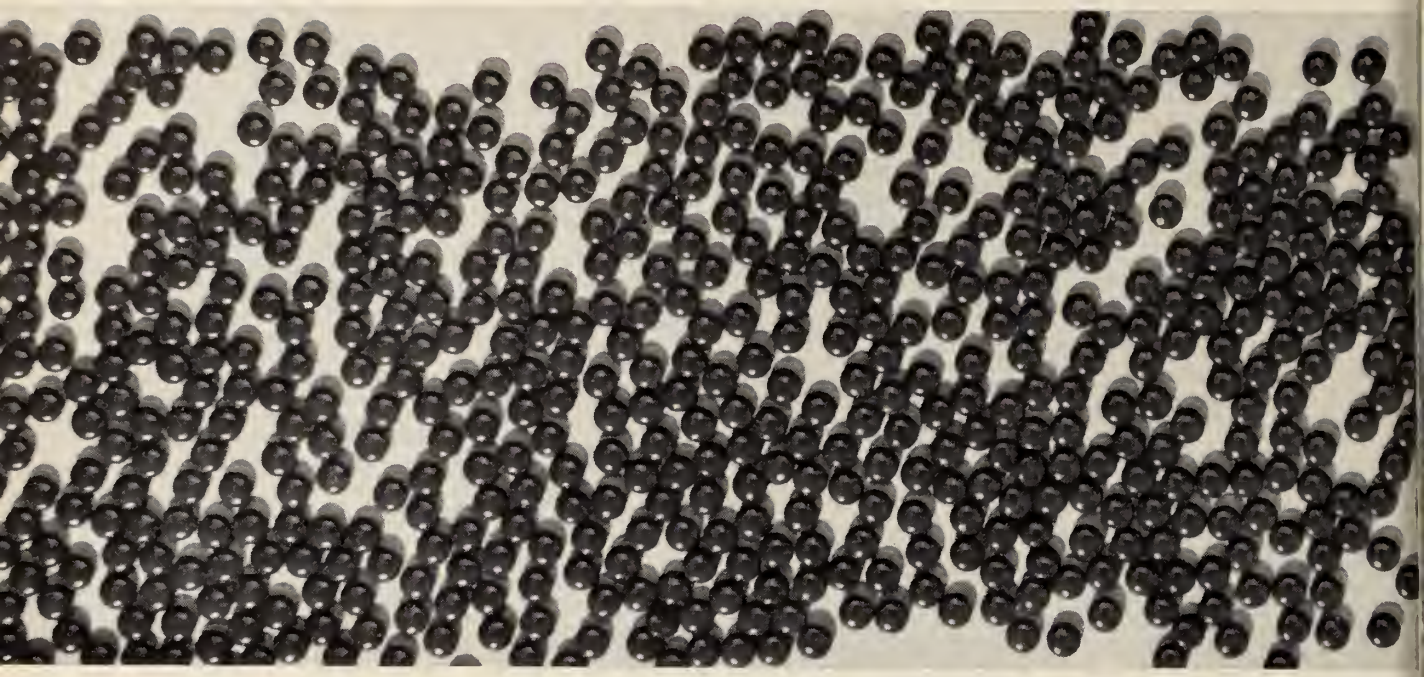
1 Plantar tinea pedis before therapy.
2 After two weeks of therapy.
3 Six weeks later, skin essentially normal (two weeks after termination of therapy).

Clinical considerations: Although clinical studies with griseofulvin have not revealed evidence of serious toxicity, ***side effects***—as with any potent drug or antibiotic—may occur in some patients. An occasional minor decrease in leukocyte count has been observed, which was reversible when medication was discontinued. Occasionally, there may be heartburn, nausea, epigastric discomfort, diarrhea, lethargy, fatigue, psychomotor incoordination and, during the first week of therapy, headache. Studies are in progress to determine the safety of this drug during pregnancy; until the results of these studies are available, griseofulvin is contraindicated during pregnancy. ***Caution*** should be observed in patients with known penicillin-sensitivity. Should urticaria or drug rash develop, the drug should be withdrawn. ***Available*** in 125 mg., 250 mg. and 500 mg. scored tablets, bottles of 60 and 250.

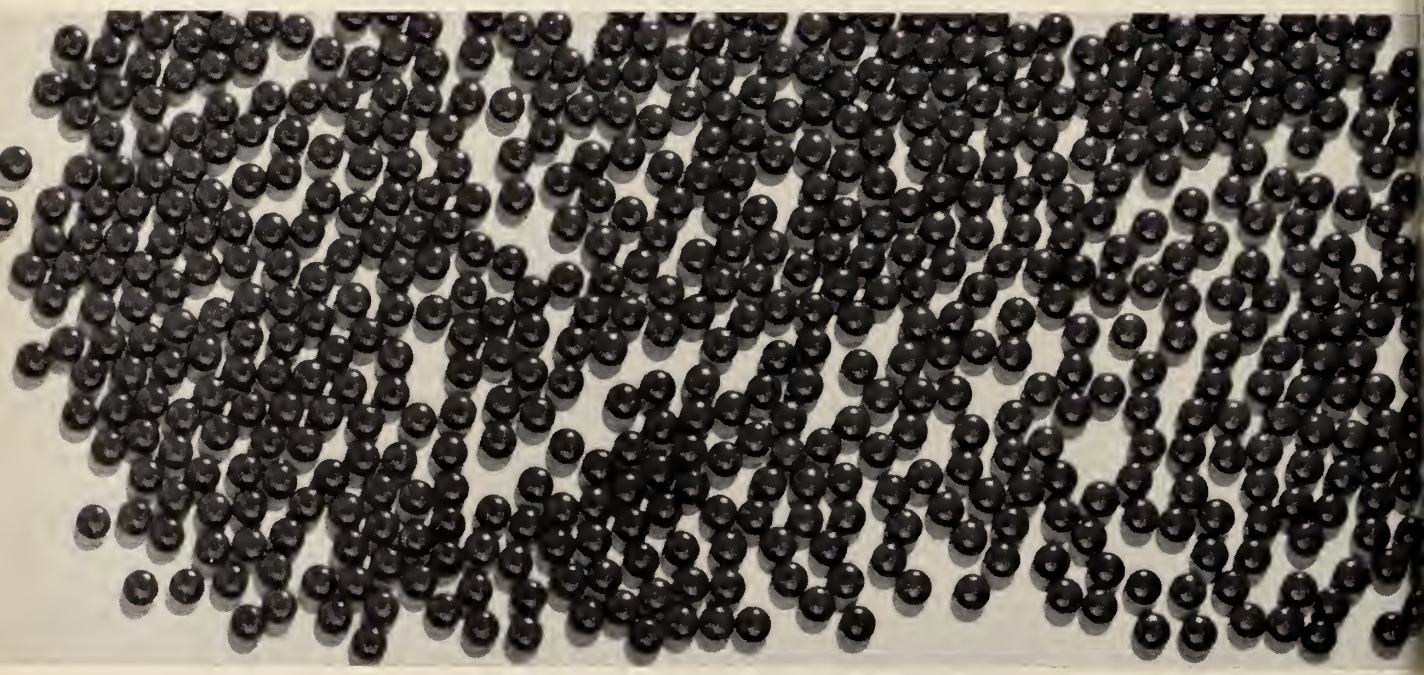
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. . . this is the other half



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Problems in Defining and Maintaining High Standards in Institutional Care

J. K. Altland, M.D.
Lansing, Michigan



COMMENTING on changes in the pattern of laboratory operations, an eminent Boston physician recently noted that with modern-day growth and complexities, "The quick grace of the ballerina has been replaced by the maneuvers of the battleship." In many respects this same notion can be applied to the problems we face in defining and maintaining high standards in institutional care. Where once we were concerned mainly with care institutions for the acutely ill, today there is a complex web of care services and facilities; where once the local hospital was largely the doctor's workshop, today there is a whole society of interests focused on our multiple-purpose institutions; and where once "standards" were defined almost solely by local competencies, today we recognize a proliferation of state and national standard-setting agencies. Thus, overall, the job of maintaining high grade institutional care standards has in the last quarter of a century become infinitely more complex, infinitely more community-oriented, and infinitely more organized.

The aspect of this milieu to be considered in this paper are those institutions where the longer term patient obtains care. This includes general hospitals, since many patients in our acute care institutions are there for a long period of time. Other institutions to be considered are county medical care facilities, licensed nursing homes and homes for the aged, and homes of less than four beds which are not currently licensed by the state health department. Mental institutions are arbitrarily excluded from our immediate perspective.

The "Standards" Concept

Standards for such institutions are goals to be reached. They are thus more than minimum requirements for licensure or for staying in business. Standards are established primarily for the protection of the patient. The American Hospital Association guide lists 13 different standards of approval to which hospitals now may be subject. These include not only state and/or local licensure for approval, but also accreditation by the Joint Commission on Hospital Accreditation, medical school affiliation, internship and residency programs approved by the American Medical Association, approved professional and/or practical nurse training schools, cancer

Doctor Altland is Associate Commissioner and Director of Medical Services, Michigan Department of Health.

programs approved by the American College of Surgeons, Blue Cross-Blue Shield programs and approved home care programs. The care institution today thus is bombarded by an increasing number of groups demanding more and higher standards, sometimes conflicting ones. Yet in Michigan there are many more chronically ill persons needing care than there are beds for them in places operating as care institutions. Under these circumstances, it is doubly important to insure minimum standards of quality care for patients on a uniform basis. Standards will, of course, vary with the type of institution and the type of patient under care. In considering the kind and scope of standards needed, we should reflect further on changes taking place in institutional care.

Transitions and Problems

As stated by Dr. E. L. Crosby, Director of the American Hospital Association:

"The general hospital is in transition. The greatest change will be the metamorphosis of the hospital from a diagnostic and curative headquarters into a community health center, with all that this entails. The outpatient department will be at least of equal importance with inpatient facilities."

As further definition, the Commission on Hospital Care has summarized four basic functions of the "new type" general hospital. The hospital, the Commission stated, is a workshop for physicians; it is an educational center; it is a center for medical research; and it is a center for community health, including the prevention of disease, care of ambulatory patients, and home care.

Finally, according to Dr. Jack Haldeman, director, Hospital and Medical Facilities Division of the U. S. Public Health Service:

"The progressive care concept envisions the general hospital of the future as a community health center—the focus for both outpatient and inpatient care; as much concerned with care for the long-term patient (including mentally ill) as it is now with care for the short-term patient; as much concerned with extending good medical and hospital care to the home by assisting the physician in the care of the patient at home as with assisting him with the care of the patient in the hospital; as much concerned with providing continuity of care for patients being transferred to paramedical institutions as with providing continuity of care for patients within the walls of its own building."

The above statements are well intended long range predictions, but there are problems in the pattern as it unfolds. True, some Michigan hospitals have initiated progressive care; others have built chronic disease wings; and still others have developed nursing home services in conjunction with acute facilities. However, overall, few general hospitals are either equipped or philosophically oriented toward the fulfillment of the full range of modern care concepts. Most hospitals are still primarily concerned with the treatment of the short-term, acute illness. Preventive medicine, ambulatory care, the problems of care of the chronically ill, research, and health education are secondary in the usual list of priorities. Even in the traditional areas of care for the acutely ill, many hospitals are still striving to reach original standards or "goals." For example, minimum standards established by the Joint Commission on Hospital Accreditation are met by only 58% of Michigan's hospitals with 25 or more beds. Similarly, hospitals of less than 25 beds have difficulty meeting the minimal requirements for state health department licensing and certification programs.

Signs of Progress

While there is thus a significant lag between newer concepts in institutional care and present practice, it is equally true that significant changes have taken place, and along with change, much progress.

As examples:

1. The type of hospital admission has changed.
2. The proportion of ward beds has declined.
3. The proportion of hospitals with advanced technological equipment has continued to rise.

Between 1946 and 1958, the percentage of short-term hospitals with clinical laboratories rose from 76 per cent to 96 per cent. In 1946, radioactive isotope therapy did not appear in the American Hospital Association's list of facilities, but in 1958, some 18 per cent of the hospitals were offering such services, and this percentage continues to increase. As late as 1946, patients averaged four laboratory procedures per admission; the average now is more than 14 procedures per patient admitted.

Dr. Howard Rusk, Professor of Physical Medicine, New York University Medical School, has pointed out that today only one-third of the space in a modern hospital is reserved for patients; the rest is for all the modern technological equipment needed for therapy—the scientific ammunition which requires an army of workers categorized by 200 different job descriptions.

Indicative of the increases in personnel in care institutions, Table I shows the current ratio of personnel per patient on a national basis.

TABLE I. EMPLOYEE PER PATIENT RATIO—U.S.—1961

Hospital Size	Short Term General	Chronic and Convalescent
Under 25 beds	2.14	1.19
25—49	2.06	1.58
50—99	2.17	1.09
100—199	2.32	1.05
200—299	2.45	.84
300—399	2.43	.88
400—499	2.44	.89
500 and over	2.40	.89
National average	2.35	.92

The data in Table II appear to indicate that the personnel ratio in Michigan is somewhat above the national average for general hospitals, but below the national average for chronic disease facilities.

The factors cited above, together with the forecasts of future transitions, are among those which must be considered by groups and agencies responsible for developing and maintaining standards of institutional care.

Application of Standards

In our Michigan experience, reasonable minimum standards can be established only with the help of the widest variety of specialists who are knowledgeable about care institutions. Once developed, such standards are established as the legal yardstick for evaluating facilities and patient care. The application of this measuring device is gradual, at a rate which will not close needed facilities but will raise the level of care where it is substandard.

Periodically, in the forcing temperature of changes such as those cited above, standards must be revised. This is again done with the consultation and advice of experts in the various fields—including those working in the institutions where the standards will be applied.

To judge the individual institution adequately, the standard setting agency must keep abreast of the latest practices for patient care. This requires a staff of well-trained persons who understand administration, nursing, and physical environment. This team of evaluators must have the knowledge and skills to help care institutions understand the need for meeting minimum standards, and how to make necessary changes and improvements in an economical and practical fashion. Safety of equipment, safety of environment, safety of construction, and safety of patient care are extremely important to those evaluating and to the hospitals as well. As an illustration, the control of staphylococcal infections, particularly the strain 80-81 variety calls into play every safety measure listed.

As well as offering consultation to individual institutions, those responsible for helping facilities to reach and maintain high standards can be of further assistance by developing training programs both for hospital aides and, on a short-course basis, for professional personnel.

TABLE II.

EMPLOYEE PER PATIENT RATIO—MICHIGAN—1961

	National	Michigan
General Hospital	2.35	2.44
Chronic Disease Hospital	.92	.77
County Medical Care Facility	NA	.7 to 1
Nursing Home	NA	.5 to .6
Home for the Aged	NA	No information

Institutions Other Than Hospitals

Institutions other than hospitals caring for the long term patient have standards and available consultation and evaluation similar to hospitals. The health department program of consultation and licensing—standard setting—for nursing homes and homes for the aged is administered and carried out apart from the hospital program. Minimum requirements are of course different, although the procedure for developing standards is much the same.

It might be expected that maintaining high standards in hospitals and nursing homes would be beneficial to both types of institutions. Nursing homes would benefit through consultation services in nursing, dietetics, physical therapy, occupational therapy, emergency services, group purchasing, laundry, and others. Hopefully, hospitals would be able to use nursing home facilities for convalescent care of patients needing skilled nursing who no longer require all the specialized and intensive care available in a hospital. The transfer of such patients would make acute beds available for patients who do require such services. Efforts to date in Michigan have fallen short of producing the full range of benefits, but it is hoped that care institutions will continue to strive for a working partnership which will provide the most effective, least expensive care under high standards.

Conclusion

Currently, in Michigan, most care institutions operate under standards developed through state government. Ninety-five per cent of our hospitals are covered, and 88 per cent of the beds in nursing homes and homes for the aged of four beds or more are in licensed facilities. While a great deal remains to be done to bring both the standards and the institutions up to our ideals of modern institutional care, past efforts tell us that much can be achieved if all groups concerned continue to work together in this field. Together, we can develop and maintain high standards. Together, we can reach the goals of progressive care. Together, we can learn how to make the battleship run.

The Hill-Burton Program

Its Role in Providing Rehabilitation Centers And Long-Term Care Facilities

Joseph R. Homminga
Lansing, Michigan

THE TERM "Hill-Burton" has become synonymous with Hospital and Medical Facilities Construction. The Hill-Burton program takes its name from the two Senators who introduced the Hospital Survey and Construction Act which was adopted by Congress in 1946. The stated purpose of the act is to assist the states to (a) inventory their existing hospitals, (b) survey the need for construction of hospitals, (c) develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital, clinic and similar services to all their people, (d) assist in the construction of public and other nonprofit hospitals in accordance with such programs.

In 1954, the Hill-Burton Act was amended to place emphasis on provision of facilities for the chronically ill and disabled and to authorize appropriations for rehabilitation centers and other long-term care facilities, such as nursing homes.

In Michigan, state legislation in 1947 provided for the Office of Hospital Survey and Construction to administer the program at the state level, established the Michigan Advisory Hospital Council composed primarily of representatives of physician and hospital organizations, and required standards of maintenance and operation for facilities constructed with Hill-Burton assistance. In 1959, in order to centralize state health activities and programs, the legislature abolished the Office of Hospital Survey and Construction and transferred its duties and responsibilities to the State Health Commissioner.

Rehabilitation and long-term care facilities have always been eligible for grants under the Hill-Burton program, provided they were part of a hospital. Until rather recently, however, there has been little interest on the part of hospitals and health agencies in providing definitive facilities and programs for the long-term care patients who require medical and related services for a prolonged period. This group includes those with a short prognosis for survival but in need of sheltered palliative treatment, those with a long-term expectation of survival but little potential for improvement, and those with a long-term potential for partial or full restoration of function.

The reasons for lack of interest at the community level in adequate facilities, program and staff for the long-term patient were, and to some extent still are, many and varied. They include (a) the backlog of need for construction of acute care facilities, (b) the limited financial resources available for capital expenditure for health facilities, with acute care facilities and programs having preference, (c) hospital and health organizations not recognizing the need for rehabilitation and long-term care facilities, (d) lack of resources for payment for care over extended periods, (e) lack of recognition of the potential benefits to the patient and the community in application of rehabilitation concepts and programs, (f) negative attitudes and philosophies on the part of hospital and health professionals as to the worth of using resources for the care, treatment and rehabilitation of the chronically ill and disabled, especially if the patient did not have a vocational potential.

Many of the factors that have deterred development of adequate facilities and programs for the long-term patient are gradually vanishing. With the help of Hill-Burton funds, the quantity and quality of acute care facilities has been increased and in most areas of the state are reasonably adequate. There has been increasing recognition of the need for adequate long-term care and rehabilitation facilities. Limited funds are being made available from tax sources, private capital and voluntary giving for longterm care facilities. There has been more interest on the part of third parties in providing insurance coverage for long-term care patients under active treatment programs, and additional tax resources have been made available

Mr. Homminga is Director of the Hospital and Medical Facilities Division, Michigan Department of Health.

to pay for care for the medically indigent. Interest has increased and attitudes are changing. Where positive and forward looking programs are in operation, the attitudes that "nothnig can be done," "it's too expensive," "why rehabilitate those not going back to work" are no longer prevalent.

The Hill-Burton program is often construed as involving only construction with a role limited to a portion of the cost of the bricks and mortar. However, the declared purpose of the Hill-Burton Act, to provide adequate hospital, clinic and similar services to all people, goes beyond the bricks and mortar. Adequate services encompass more than the mere building and equipment. In order that a well-equipped building may have the potential for service and provision of an acceptable standard of care and treatment, Hill-Burton's role is to provide guidance so the facility is designed to provide the specific service or services required to meet the predetermined need and the purpose for which it is being constructed. For Hill-Burton approval, the facility must be sized in relation to potential use, have the potential of being adequately staffed by necessary medical and paramedical personnel, and be located where adequate staff is available or can be made available. The project and program must have the broad support of the residents of the area for both construction and operation. It must have competent and progressive administration both for day-to-day operations and determination of policy. It must be able to function efficiently and economically. The safety of the patient and staff must be considered. Maximum facilities and services for the dollar expended, both for capital investment and care, is an objective of the Hill-Burton program.

In Michigan the administration of the Hill-Burton program for all types of facilities has been undertaken according to specific guiding principles and goals. These include the following:

1. Development of a coordinated system of health care institutions providing reasonable access by all people to facilities and services of high quality, without unnecessary duplication.

2. Encourage the development of needed and properly staffed services and forward looking programs.

3. Public funds are to be utilized and expended in an efficient and economical manner.

4. The services of facilities constructed with the assistance of Hill-Burton funds be made available to all patients in the area that can benefit from the services so provided.

5. Facilities constructed with Hill-Burton assistance be of a size conducive to supporting necessary skills, staff and services in an economical manner.

6. The ability of a facility to provide services economically and of high quality is more important than the building.

In the last few years, the term "rehabilitation" has become a much used and perhaps misused term. Webster defines the term "rehabilitation" as "to restore to a former capacity; to fit to make one's livelihood again." I like to define "rehabilitation," as it relates to Hill-Burton's role in providing rehabilitation centers and long-term care facilities, as "to enable the patient to make maximum use of residual abilities so as to live as independently as possible." Rehabilitation, we believe, ranges from partial restoration to full restoration. It includes enabling the patient to progress from bed to wheelchair, taking care of personal and toilet needs, ambulation with aids, being institutionalized with lesser care and cost, being returned to domiciliary living and, of course, the ultimate goal of being income-producing. The degree of "rehabilitation" depends upon the patient and his potential, the adequacy of medical supervision and treatment, and the availablity of adequate facilities.

The State Plan for administration of the Hill-Burton funds separately programs and provides for financial assistance to construct "rehabilitation centers" and "long-term care facilities," each expected to provide services and program directed towards enabling the disabled to live as independently as possible.

The type of facility and program designated as a "rehabilitation center," the construction of which can be financially assisted from a special allotment of funds, is defined in Federal regulations as a comprehensive multi-purpose disability center*

". . . which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program, under competent professional supervision, of (i) medical evaluation and services, and (ii) psychological, social, or vocational evaluation and services. The major portion of the required evaluation and services must be furnished within the facility; and the facility must be operated either in connection with a hospital or as a facility in which all medical and related health services are prescribed by, or are under the general direction of, persons licensed to practice medicine or surgery in the State.

An integrated program brings together as a team specialized personnel from the (i) medical, and (ii) psychological, social, or vocational areas for the purpose of pooling information, interpretations and opinions for the development of a rehabilitation plan of services in which the disabled individual is viewed as a whole. When members of the team

*Public Health Service Regulations, Section 53.1(t)

contribute to the diagnosis and treatment of illness, their contributions must be coordinated under medical responsibility."

A rehabilitation center can only be located where there is available qualified staff with the necessary skills. The area served must have a sufficient population base to provide enough patients to support the necessary range of services and staff. To avoid duplication and provide comprehensive services, centers should be closely affiliated with hospitals, physically and operationally. In Michigan, first priority for financial assistance in the construction of rehabilitation centers is for projects located in areas with medical schools. In this situation, the facilities not only provide direct patient services, but also contribute to the teaching, training and research programs. In this priority, Hill-Burton funds have assisted in providing the Rehabilitation Institute in Detroit and an expansion of facilities for the Department of Physical Medicine at University Hospital in Ann Arbor.

Second priority for assistance is for centers in other large urban and medical centers where the skills and staff are available or can be made available and the need is justified by a sufficient volume of patients. In larger communities without medical schools, the Rehabilitation Medical Center in Lansing, which is affiliated with Edward W. Sparrow Hospital, and the Chronic Disease and Rehabilitation Unit of Saginaw County Hospital have been constructed with Hill-Burton assistance.

Prime requisites for establishment of a rehabilitation center include a definite interest of physicians in an area; a willingness of various organizations concerned with or interested in rehabilitation services and program to consolidate and pool resources, programs, and knowledge; adequate financial support for operation; cooperation between the administrations of acute and long-term care facilities and public agencies; and a sufficient population base.

It is believed that all facilities for care of the so-called long-term, chronically ill and disabled patient should be oriented to rehabilitation concepts, treatment programs and philosophies. All longterm care facilities cannot have nor are they expected to have the skills, services and equipment of a rehabilitation center. In a coordinated rehabilitation service and program, there needs to be development and implementation of relationships between the rehabilitation centers and other long-term care facilities, whether they be county medical care facilities, units with general hospitals or private facilities. The relationship can include educational and training programs for staffs, sharing of personnel on a consulting basis, arrangements for transfers between institutions in relation to the patient's need for the services provided, and an understanding of the program and services of the rehabilitation center by physicians and by administrators of longterm care facilities outside the immediate location of the center.

In addition to rehabilitation centers, Hill-Burton funds can assist in the construction of long-term care facilities. These are defined in Federal regulations as facilities which are*

". . . operated in connection with a hospital, or in which nursing care and medical services are prescribed by or performed under the general direction of persons licensed to practice medicine or surgery within the State, for the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care, but who require skilled nursing care and related medical services . . . because of illness, disease, or physical or mental infirmity. . . ."

It is recognized that not all of the physically and mentally disabled can be restored to former capacity or enabled to earn a living again, as Webster defines "rehabilitation." Also, all cannot be restored to a level of self-care to live independently, but those who can be restored to living outside the institution or even with some independence and dignity within institutions should be given the opportunity. Hill-Burton's purpose in part is to construct facilities to provide adequate hospital, clinic and similar services to all the people. In interpreting this purpose, we interpret the word "adequate" to mean "necessary." Necessary facilities should not include facilities for the continual institutional care of those that can be returned to a level of self-care for independent living outside the institution. To return as many as possible to independent living is a prime requisite to reducing the financial burdens of capital investment and cost of care on communities and individuals. Hill-Burton does not believe bigger buildings is always the answer. Often the solution is not a matter of facilities, but the redirection and interest of those involved in administration of the total program of longterm care and establishment of out-of-hospital services.

In order that there is reasonable assurance that a long-term care facility constructed with Hill-Burton assistance will fulfill the purpose for which it is constructed, certain program elements have been established as to location, staffing and operation of facilities constructed with Hill-Burton assistance. Assurances from the applicant for funds as to compliance

*Public Health Service Regulations, Section 53.1(u)

with these elements is a basic requirement in approving a grant.

These elements were established as guidelines with the advice of the Michigan Advisory Hospital Council and in consultation with medical, paramedical and allied professional people in direct contact with operation and guidance of facilities and programs for the care and rehabilitation of the chronically ill and disabled. They are applicable to all long-term or extended care facilities assisted with Hill-Burton funds, whether they be county medical care facilities, voluntary nonprofit nursing homes, or long-term care units that are integral parts of a general hospital. In general, the program elements include the following requirements and assurances.

1. A new facility must be located in the mainstream of medical care, in a community with an acceptable general hospital programmed in the State Plan for continued existence and as close as possible to a hospital. In cases where there is sufficient site adjacent to the hospital, the long-term care facility shall be adjacent to the hospital, and ancillary services shall be shared to the fullest extent possible on an equitable basis. All new facilities shall be in a location served or able to be served by public utilities.

2. The facility shall be operated without discrimination as to race, creed and color, and shall be open to both self-supporting and tax-supported patients.

3. All facilities shall meet applicable licensing, certification and approval requirements; and in the case of a hospital unit, the entire hospital shall meet the standards for accreditation by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association, whichever is applicable.

4. A program planning committee shall be established to provide broad community understanding and support of the longterm care program, with representation of the hospital administration, physicians, nursing profession, county department of social welfare, health and welfare committees of the county board of supervisors, Bureau of Social Aid, local health department, volunteer organizations serving the hospital and other health agencies, and such other persons as may be deemed desirable in the particular area.

5. Assurance of support of the program by the physicians in the area and assurance that the physicians will assist in the development of the medical program and policies of operation, implementation of educational programs for physicians and personnel serving the long-term patient, creation of an organized medical staff, and appointment of a chief of service or medical director of the longterm unit.

6. Assurance of a planned program for procuring adequate personnel and medical consultation and supervision. Necessary personnel includes professional and auxiliary nursing personnel in relation to the needs of the kind of patients to be admitted; consultation services from physiatrist or orthopedist; qualified physical and occupational therapists, full or part-time as may be deemed necessary; consultation services from a psychologist or psychiatrist to work with the patients and staff; a qualified administrator; a social worker (preferably a medical social worker) to assist in solution of social or emotional problems of the patient and family and to expedite discharge to the community; and a medical director or chief of service with special interest in rehabilitation and care of the long-term care patient.

7. Assurance that training programs shall be provided, including a short course in rehabilitation nursing for at least one member of the nursing staff at an approved school; inservice training for all personnel using consultants experienced in the care of the longterm patient; instruction for physical, occupational and diversional therapy aides, either by approved short courses when available or by inservice training at an established longterm care unit; and orientation to rehabilitation programs for at least one member of the medical staff.

8. Assurance that arrangements and policies will be developed for transfer and referral of patients to other facilities and programs as needed, including general hospitals, rehabilitation centers, foster and personal care homes, State Division of Vocational Rehabilitation, and home care services.

9. Assurance that home care programs and outpatient services under medical supervision will be developed to enable the patient to live outside the institution whenever possible.

10. Assurance that operating financial arrangements will be developed, including an operating budget, setting forth the estimated costs, the estimated charges for services, and estimated income. Methods for determination of costs and charges for services where services are shared with another facility must be

formalized and agreed upon. In case of a hospital or voluntary nonprofit longterm care facility, an agreement with the county welfare officials on use of the facility for county patients and payment for care is required.

In summary, the Hill-Burton program has a role in providing rehabilitation centers and longterm care facilities, but the role is broader and more comprehensive than just paying a portion of the cost of a building and equipment.

In the course of providing a building, the Hill-Burton Agency must be reasonably sure that the facility is designed to function economically and efficiently, that facilities and services are provided to serve and treat the type of patients to receive care, that the facility will be properly staffed and have medical supervision, that there is a need for the service, that the facility will be adequately utilized, that the facility can be operated efficiently and economically and render a community service, and that sufficient financial resources for operation can be made available.

Although Hill-Burton has a role in providing rehabilitation centers and long-term care facilities, the major responsibility belongs to the community leaders, and especially the physicians. The building may be architecturally and esthetically perfect, the nursing staff may be well trained, the governing board may be progressive and dedicated, the community may provide financial resources, voluntary and public agencies may cooperate, but without the interest, understanding, dedication and help of the physicians to provide the medical supervision and an adequate treatment program, the most adequate building will not receive maximum use and provide maximum benefits to the area served.

Some time ago I attended a meeting of individuals of various professions interested in care and treatment of the longterm patient. Present were physiatrists, orthopedists, general practitioners, public health physicians, psychiatrists, psychologists, rehabilitation nurses, medical directors of rehabilitation centers, social workers, physical therapists, occupational therapists, administrators of county medical care facilities, and representatives of prepayment plans. The needed services, staffs and programs of longterm care facilities were discussed in detail, resulting in various conclusions and recommendations. One of the conclusions that impressed me was that unless there was at least one physician in the area who had a special interest in the care, treatment and rehabilitation of the chronically ill and disabled, a facility might better not be built.

Hill-Burton has a role in providing rehabilitation centers and longterm care facilities, but it cannot fulfill that role without the help of physicians.

Aerospace Medicine and Honors

"Generally speaking, there is no creation of our civilization which pushes the frontiers of knowledge in so many directions as the design, fabrication, and operation of space craft," A. H. Schwichtenberg, M.D., head of the Department of Aerospace Medicine and Bioastronautics, Lovelace Foundation, told the recent American Industrial Health Conference in Washington, D. C.

"It is my belief," he said, "that our national efforts in defense and in space, more than anything else we do, spark the remarkable acceleration in rate of progress in scientific and technological fields."

United States Steel Corporation was honored with the "1963 Health Achievement in Industry Award" which is presented annually by the Industrial Medical Association to the management of industrial concerns for having promoted the development of outstanding occupational health programs.

"The Meritorious Service Award" of the Association was presented to Arthur K. Peterson, M.D., Medical Director, R. R. Donnelley and Sons Company, Chicago, for distinguished and extraordinary service.

W. Daggett Norwood, M.D., of Richland, Washington, was accorded the highest honor in the field of industrial medicine. The Industrial Medical Association conferred upon him the William S. Knudsen Award for his "outstanding contribution to industrial medicine." Dr. Norwood has achieved wide acclaim for his work in identifying the health aspects of occupational exposure to ionizing radiation.

How Care of Patients in Nursing Homes Could Be Improved

V. K. Volk, M.D., Dr. P.H.
Richard S. Ryan, M.D.
Charles Sellers, M.D.

Saginaw, Michigan

MEDICAL care of aged patients has vastly improved during recent years to the point that many older patients could benefit from an active rehabilitation program and the more advanced medical knowledge in the field of geriatrics. There comes a time, however, when the rehabilitation program cannot improve the status of some geriatric patients and of necessity custodial care is needed for a prolonged period. For such patients, nursing homes appear to be the logical place where they could get proper daily care and limited professional medical attention needed.

In the State of Michigan, 16,341 beds for geriatric patients are available in 433 nursing homes. Between 50 and 60 per cent of the beds are occupied by welfare cases. According to Kenton Winters of the School of Public Health, the general occupancy of the beds in Michigan in 1960 was 86 per cent.

Nursing Homes Then and Now

Several years ago, the Michigan Department of Health undertook the licensing of nursing homes and established more rigid requirements and better supervision. The nursing homes have greatly improved their services to patients. In these important efforts, local health departments have played significant roles by maintaining close supervision of nursing homes.

Many improvements were made in nursing homes but there remain problems that need to be resolved in the homes themselves, their administration, and their services to patients. The old reputation of nursing homes being a place of last resort must be overcome. The operators must recognize their full responsibilities and show a spirit of dedication but they cannot do it by themselves. They must have the cooperation of other members of the team, physicians, social welfare directors, health department personnel, and community groups.

Doctor Volk is Health Commissioner, Saginaw County.
Doctor Ryan is Health Officer, City of Saginaw.

Some Guidelines

Our experience with nursing homes leads us to believe there are several well-defined and recognized guidelines that should be accepted by nursing home operators.

1. The nursing homes must be functionally sound and safe for the patients.
2. They should be professionally staffed insofar as this is possible to insure adequate service to patients.
3. Nursing home operators must be dedicated to the project of managing the nursing homes.
4. Nursing home operators must be reimbursed adequately so they can render acceptable service to patients.

The first condition could be solved by postponing licensure until the requirements are met, local health departments should not compromise in this matter.

The second suggestion requires realistic judgment since it is difficult to secure professional personnel; however, every nursing home should have several trained non-professional employees who know the fundamentals of good patient care and who could manage until professional personnel could be secured.

The third guideline implies that administrators of nursing homes must be more than owners and more than businessmen. They should understand geriatric patients and be well oriented in their needs before being allowed to run a nursing home. The owner of a nursing home should prove his fitness before being permitted to operate it. His education, personal qualifications, integrity, and habits must be favorably known to the health department and be considered prior to licensing.

Role of Welfare Director

Nursing home operators should be adequately reimbursed to insure acceptable services to patients. Nursing homes cannot operate at a loss; if they are

inadequately compensated, services will inevitably be curtailed. With presently available financial support from state and federal governments nursing homes should be reasonably paid with due consideration to programs and services provided. The personnel can either make or break a good nursing home, therefore operators must be selective about their employees.

Role of Family Physician

The family physician is very important, therefore we wish to stress the need for physicians accepting the responsibility of seeing their patients in nursing homes. Sometimes the situation is out of control of the family physician because of the prevailing "system" of admissions. It is not proper to admit a patient to a nursing home without prior evaluation of the patient by a physician. Sometimes the family does not call in a physician until the patient's condition becomes urgent. Under these circumstances it is difficult for the physician to make a diagnosis, to outline treatment, and to give orders to the nursing home personnel. One of the basic needs for better care of the aged in nursing homes is to have a complete evaluation of the patient's condition *prior to admission to the home preferably in a hospital.* Patients should be admitted to a nursing home only from a hospital where recent diagnostic work has been done. This evaluation would determine whether the patient should be in a nursing home or in a hospital. This information should be made available to the nursing home operator. Even though the physician knows well the condition of the patient there may be occasions when the physician is unable to supervise the care of the patient and must delegate this responsibility to an alternate. Having the history and other pertinent information would be most helpful to other physicians. Indeed, state regulations require a history and physical examination within a reasonable time after admission usually interpreted as 48 hours. Frequently this is not done.

State law requires quarterly medical progress reports to be completed by the attending physician. Every patient should be visited at least once a month. If more frequent visits are needed, it would be wise to consider transferring the patient to a hospital.

Medical Advisors to Nursing Homes

The role of physicians is important in the care of patients in nursing homes. We know physicians try to serve the needs of their patients but sometimes it is difficult for a busy doctor to visit nursing homes regularly. Perhaps the problem could be solved by having a medical advisor available on a consultation basis for problems about the general medical care of patients. If the family physician were unavailable for any reason, the medical advisor might serve *if the family physician desired.* Under no circumstance would the medical advisor assume care of a patient without a specific request from the family physician.

Role of the Health Department

The local health department acts as an agent of the State Health Commissioner in supervising nursing homes and in determining if the state requirements are complied with and the patients' needs are actually met. This applies to qualifications of personnel, meeting legal requirements such as employment of registered nurses and licensed practical nurses and also of practicing good nursing. The health department also has the responsibility of checking the pharmacy and seeing that the drug records are in good order. Health officers have the right to periodic review of patients' records but are reluctant to do so without prior knowledge and consent of the attending physician.

The medical profession should support local health departments in their efforts to improve every phase of nursing home administration. Few of the nursing home operators had any prior experience in the administration of nursing homes. They need help. Local health departments are offering much needed help without infringing in any way on the role of physicians or medical care of patients.

Women's Auxiliaries and Friendly Visitors

Patients in nursing homes are entitled to opportunities for social living. Many of them would enjoy movies or other types of entertainment and participation in religious services. With prevailing scarcity of help, it is unrealistic to expect operators to provide these opportunities in their own nursing homes. It occurred to us that neighborhood auxiliaries and friendly visitors might help the operators to meet the social needs of patients and to stimulate the employees to participate. This should help to improve the morale of patients and the general appearance of nursing homes. Through citizen participation, the community would be more aware of the needs of both patients and the nursing homes. If there are no community organizations or agencies available, the health department might well initiate this activity.

Some patients may need to maintain the benefits attained in general hospitals or rehabilitation centers prior to admission to nursing homes. It would be well to consider a community-wide effort for a group of nursing home operators to engage jointly physical or

occupational therapists. By working together, these medically related specialists could teach the personnel in the nursing homes the basic principles of physical and occupational therapy.

In presenting this brief outline on how to improve the care of patients in nursing homes, we would like to stress the following:

1. The nursing home has a very important role in the care of custodial patients, therefore it should be geared to this service. Granting there might be some exceptions, the great majority of nursing homes need not aspire to the "glamour" of a professional rehabilitation service. Nursing homes should not be diverted from their essential purpose of providing adequate custodial care to patients.

2. Physicians are the "key men" on the team. Even if their visits are made only on a monthly basis, they could exert tremendous influence toward patients receiving the best possible medical care. After all, physicians direct patients to nursing homes and naturally would be most favorably impressed by the most cooperative nursing home operators.

3. Compensation to nursing home operators must be adequate for services rendered.

4. Health departments could do much to make nursing homes more desirable places for the care of custodial patients. Frequent visits by health department personnel, sympathetic guidance, and necessary firmness will insure compliance with all reasonable requirements.

5. Neighborhood auxiliaries could render help to nursing home operators.

6. These efforts would help the families of patients to understand the situation a little better and to gain their respect for nursing homes. Operators should inform the family when arrangements for admission are made that they are expected to pay for the monthly visits of the physician. Every nursing home should make this a rule.

7. Finally, the people in the community should remember the patients in nursing homes the same as those in general hospitals. They, too, need the kind heart, warm hands, and bright smiles of women's auxiliaries and friendly visitors.

Health and Safety Tips from the American Medical Association

Do you have warts? If so, you have a lot of company. Many people, particularly children, have warts. Sometimes they hang on for years. Often they just go away after a while, for no known reason. Usually a wart is nothing to worry about.

A wart is a virus infection of the outer layer of the skin, says *Today's Health*, the magazine of the American Medical Association. The ordinary wart is a benign tumor that does not turn into cancer.

Warts can turn up anywhere on the body, but are most common on the hands, fingers and soles of the feet. Girls are four or five times more likely to have warts than boys, but in adults the incidence is about the same for both sexes. Warts are contagious and are started by contact with the virus that causes them.

The plantar warts (those on the soles of the feet) cause the most trouble. These are most common in adolescents and adults with moist feet. Plantar warts occur most often at points of pressure and sometimes can be confused with painful calluses. They can be most uncomfortable, even making walking painful.

Physicians generally use either an electric needle or a freezing process to remove warts. Either process will work and the choice is up to the individual doctor.

For some unknown reason, warts sometimes can be "charmed" away by suggestion. Mark Twain readers still recall the stumpwater and dead cat remedies of Tom Sawyer. If the patient firmly believes the remedy will cure warts, sometimes it will. Sometimes the physician will destroy the largest wart and then find that the smaller ones go away without further treatment.

If a wart is so located that it is constantly irritated and causes discomfort, such as a facial wart that gets in the way of shaving, or is unsightly, it is advisable to have it removed.

Most of the non-prescription wart remedies contain acid. These could cause harmful burns if the patient did not follow directions carefully.

If you have a wart that is located in an irritating spot or is causing an unsightly appearance, consult your doctor and follow his advice on whether it should be removed and what removal procedure to follow.

The General Hospital And Care of the Aged

A. Hazen Price, M.D.
Detroit, Michigan

THE GENERAL hospital has a real responsibility in the care of the elderly patient. As our population continues to increase, with a higher percentage of older people than ever before, it is logical to assume that the number of persons 65 years and older occupying hospital beds will steadily increase year after year. In addition to providing the necessary care in acute illness, hospitals must also plan their facilities so the patient with chronic illness will receive the kind of care necessary to rehabilitate him to a point of self-care whenever possible.

Most general hospitals are built and operated to provide care for acutely ill patients and as a consequence the person with a chronic disability may not receive the best care possible from the nursing or resident medical staff. This is understandable, for patients with acute illnesses have first priority, and this is as it should be. Residents and nurses in training are taught the proper care of those patients with acute illness but oftentimes little time is spent in teaching the newer concepts of rehabilitative care for the patient with a chronic disabling illness.

In order to improve the care of these patients, it is suggested that all general hospitals of 200 or more beds should have a chronic wing set aside for this purpose. In the smaller institutions, 10 to 12 beds should suffice, whereas in larger hospitals, 25 or more beds could easily be filled at all times with patients having hemiplegia, arthritis, chronic cardiac difficulties, neurologic and even orthopedic problems. Repeated surveys in a large 600-bed hospital have shown that 20 to 25 patients are occupying beds at all times on floors for acute cases who might be more economically and advantageously cared for in a wing devoted to chronic cases. Most of these patients have been in the older age group, while only a few have been in the 20 to 40 age range.



The Author
A. HAZEN PRICE, M.D.

Patients with long-term illnesses must be taught self-care in every way possible, thereby shortening their hospital stay and helping them and their families to understand the various ways of living with their disability after they return home. It is obvious, therefore, that physicians, nurses' aids, ward helpers and orderlies in this unit must have special training in this type of care in order that the patient can derive the most help. This know-how is essential for good results and very few people in the acute hospitals of today have had this kind of training. Unfortunately, some persons are not well adapted for the care of patients with chronic illness and their presence may actually be bad psychologically for the chronically disabled individual. Only those who are truly interested, with a good sense of humor and an optimistic attitude, can hope to become good members of a rehabilitative team.

In a unit of this type, research projects in geriatric medicine could well be carried out, as well as providing a training ground for nurses, interns and students in the care of the chronically ill. An outstanding example of this type of facility in our own state is found in Traverse City at the James Decker Munson Hospital and in New York City at the Montefiore Hospital.

In the smaller general hospital, it may not be feasible to set aside beds for this purpose. In this case, a close liaison may well be established with a good nursing home in the neighborhood so that patients may easily be transferred to this type of facility as soon as

Doctor Price is Chairman, Geriatrics Committee, Michigan State Medical Society; Clinical Assistant Professor of Medicine, Wayne State University.

the acute phase of illness has passed. I am well aware that as long as a patient has hospitalization insurance, he would be unwilling to go to a nursing home where he would be required to pay his way. This is again a good reason why hospitals should provide a chronic disease facility as part of their institution so patients could be given appropriate care for a longer period but in a less costly unit than in the acute care division of the hospital. It has been shown that if patients with chronic illness are given the benefit of modern methods of rehabilitation, they learn to care for themselves, can go to their own homes much earlier, and are better adjusted to the ways of living with their disability.

In the future, a closer relationship should be established between the hospital and the nursing home. The quality of care in many nursing homes has improved tremendously in the past few years, yet in many the patient care leaves much to be desired. While the licensure and supervision of nursing homes in Michigan is now under the jurisdiction of the State Health Department, providing a greatly improved set of rules and regulations, the quality of patient care is still inferior in many of the smaller homes. The Nursing Home Association of our state is to be commended for the fine work it has done in improving the status of all nursing homes belonging to the Association, but unfortunately many are too substandard to be eligible for membership.

It seems to me, therefore, that hospitals have an added responsibility to improve the overall patient care in these homes by establishing a closer relationship with those that are near by. Some of the nursing personnel, as well as some of the house staff, might well be assigned a period of service each week which would not only improve the quality of patient care, but would also provide a place where nurses and young physicians alike would receive experience in the care of chronically ill patients. This relationship might also be extended so that some form of administrative help for the home could be given by the hospital. In some cases, a total integration of the nursing home with the hospital might be more feasible administratively, financially and professionally.

It is more than likely that in the not too distant future some type of insurance will provide for patient care in nursing homes as well as in general hospitals. When this becomes a reality, then a freer transfer of patients from hospitals to nursing homes will be commonplace and a close supervision of patient care in the nursing home will be much easier. It is to be hoped that this relationship will be established soon, thereby releasing many costly hospital beds necessary for acute illness as well as providing better care for more people with long-term illness.

Increase Reported in Homemaker Services

Homemaker services in the U.S.A. are rapidly increasing. The Public Health Service Directory of Homemaker Services listed 145 agencies in 1958 and 208 in 1962.

Voluntary agencies employed 80 per cent of the total number of homemakers, 72 per cent of the full-time homemakers and 96 per cent of the part-time homemakers. The voluntary agencies averaged 15 homemakers per agency. Almost half of these agencies employed fewer than 10 homemakers each; 8 employed 50 or more.

The largest program was in a public welfare agency—the New York City Department of Welfare—that employed 165 full-time homemakers. The next largest was a voluntary independent community agency in Florida—the Visiting Homemaker Service in Fort Lauderdale—that employed 90 full-time and 10 part-time homemakers.

Non-Profit Homes for the Aged

Some Patterns and Trends

Perry C. Gittins, M.D.
Detroit, Michigan

IN PROVIDING for the housing and care of our older people, we are no longer content with the old institutional methods. There is a trend for the development of retirement villages, high rise apartments and new modern nursing homes. Many of these innovations have been adopted and even pioneered by the non-profit homes.

The standards for building construction, safety devices and resident care have been upgraded in the proprietary as well as the non-profit homes. These facilities will continue to supply a housing as well as a paramedical function for the community needs of our older people.

Voluntary non-profit homes provide for a variety of services consistent with religious and secular groups which compose our American society. These philanthropic organizations provide a retirement home for a large number of persons who do not require nursing home care. They also plan and manage medical and nursing home facilities which provide care to those afflicted with chronic disease and infirmities associated with the aging process.

The name "Home for the Aged" is a phrase sometimes not understood and improperly used as the name for a facility providing care for older people. Due to the fact that many older people in retirement homes do not require nursing home care, the Michigan State Health Commissioner may approve a license to any home qualifying as both a nursing home and home for the aged, subject to the standards required for nursing homes for the authorized number of patients to be given nursing care.

Method of Financing

The original development of non-profit homes may be financed by gifts from the members of the church, or, if it is an association, by the benevolent generosity of its members. Expansion programs may be financed by loans from private sources, but regulations from the federal government frequently prevent non-profit homes from obtaining loans.

A non-profit home, as defined by the Department of Health, Education and Welfare, 1954, states, "this is a nursing home owned and operated by one or more incorporations, no part of the net earnings which may lawfully inure to the benefit of any shareholder or individual." It further states that nursing homes or homes for the aged who restrict services to one group or denomination are not considered to be rendering a community service. In order to qualify for a federal loan or insured F.H.A. mortgage, these homes must offer admission to other denominations. In spite of these provisions for a federal loan, non-profit homes have expanded their facilities, maintained standards in construction and upgraded the quality and quantity of services.

The budget cost has increased in proportion to the cost of living index and tend to increase as we improve standards for nursing homes.

The residents of homes for the aged are accepted with the knowledge that funds are sufficient to pay the usual rates. Many of the present generation are not fortunate enough to have had retirement and social security income and some homes have more than 20 per cent on old age assistance.

The average cost is greater than that allowed by the Department of Social Welfare. It is fortunate that non-profit homes have a number of residents with means to pay their own way and even share in the capital investment.

New Association for Non-profit Homes

The National Association of Homes for the Aging was organized, November, 1961. This offers membership to non-profit homes. "A national directory is now available and their directors plan to provide leadership, exchange information for developing standards and services." They state that "the association has sprung

Doctor Gittins is Medical Director of the Presbyterian Village; Member Geriatrics Committee of the Michigan State Medical Society.

from a genuine need for exchange of experience, technical assistance, help with staff training and education, and representation on the national scene so that homes for the aged can more effectively serve the growing number of older men and women in need of residential care."

Types of Facility and Sponsors

In the State of Michigan, there are approximately 93 non-profit homes, exclusive of government and county facilities. They accommodate 4,635 residents. This listing is according to the 1962 *Directory of Non-profit Homes*. A previous survey made by the American Nursing Home Association as of August 28, 1957, showed that Michigan had 600 proprietary homes with 10,360 beds; the non-profit homes were listed as 50 with a bed capacity of 3,047. Every year shows an increase in the number of licensed homes for the aged. The size of the homes varies. There are 10 homes having a capacity ranging from 100 to 600 occupants. The remainder of the listed homes vary in capacity from 8 to 100 beds.

The sponsors of non-profit homes have a large number of people involved in a community project. The directing boards are composed of men and women of variable experience and usually a constantly changing membership who have a continuing interest without a profit motive. There are many volunteers who provide a personal service to the residents and funds when necessary.

A facility is usually planned in terms of the community needs and the ability of the membership to support the venture. Some of the smaller homes are designed for domiciliary care and we should not expect many of the variable activities and services that are available to people who are residents of larger homes.

The organization for the Kundig Center in Detroit gives attention to older people who live in a rooming house situation in the congested urban area. They provide for the preparation of meals, recreation, counseling and some medical services. They are now in the process of constructing low cost apartments without the benefit of federal funds.

The Salvation Army has reconditioned an apartment hotel in the downtown area of Detroit. The resident must be free from illness that requires nursing attention. The low cost appeals to many of the residents. There is no nursing home now but they plan for the future development of a nursing home in the adjacent area.

Carmel Hall, in downtown Detroit, is a reconditioned former hotel. This will accommodate more than 600 residents. This is a complete service for the well aged and complete nursing home care for the residents who are ill. It is sponsored by The Carmelite Sisters who have homes of this type in other cities.

The Presbyterian Village is located in the outer area of Detroit. The one-story apartments, congregate living buildings and the nursing home area are separated but grouped in an area so as to facilitate unity in function.

The Jewish Home for the Aged will accommodate 300 persons. It is a multiple service facility offering complete care and also a day care program.

The Arnold Home of Detroit has been modernized and has a complete service for the well aged and nursing home service for the ill.

In other parts of the state, there are the Merrill Residence at Kalamazoo, Marian Hall at Flint, The Chelsea Methodist Home at Chelsea and the Lutheran Home at Monroe.

This is only a partial description of the changing patterns for service and living arrangements that are available to people in some parts of Michigan.

Conditions Affecting Homes for the Aged

Surveys show that the average age of an applicant to a home for the aged is 78 years; the average age of all residents is 81 years. Policies for retirement, social security and improved general health, make it possible for people of an older age to live in their own homes. This means that they will seek the retirement home at an advanced age when illness and disability are more prevalent. Homes for the aged are then faced with the need for providing more nursing and medical care at a cost much greater than that of a home for the well aged. They must also provide an acceptable social home-like environment for the aged who are ambulatory and have no need for nursing home care.

The "Well Aged Care"

The organizations for non-profit homes have many in their group who have interest in providing all the necessary complete services. There is support for the planned activities, such as entertainment, arts and crafts, volunteer church auxiliaries and also the help of the clergy with a regular and sustained program. Friendly visitors and volunteer drivers help keep the resident in contact with the community. Such available service lessens the need and desires for nursing and medical care.

Personal and Nursing Home Care

Unfortunately, there is a need for a well-planned medical program, always available but not emphasized. The staff of the larger homes consists of physicians who make regular calls and co-ordinate the medical care. The nursing staff is supervised by a registered nurse who will provide for in-staff training to nurses aids. The rehabilitation program is directed by a physician whose chief interest is rehabilitation.

Medical care is provided on a continuing basis, and progress recordings are made. If illness occurs, every effort is made to rehabilitate residents to their former living status. Readily available hospital services are necessary for diagnosis and treatment. People beyond the need for hospital care are returned to the nursing home, or to the well aged areas as soon as they have recovered from an illness. This cuts the cost of hospital and nursing home care.

A medical and nursing care facility is a necessary part of a well managed home for the aged and it is best to plan for one nursing home bed for every five well aged. In the nursing home area, eight to ten per cent will be disabled to the point of having no rehabilitation potential.

Summary

1. Non-profit homes are developing new housing with modern architecture and more pleasant living conditions.

2. Greater effort in planning acceptable programs of activities without regimentation.

3. More effective planning of medical, nursing and rehabilitation.

4. Non-profit homes have increasing importance to people in retirement because the cost for care of the well aged is less than nursing home care.

5. Increasing need for facilities providing for complete care.

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Harper Marks 100 Years

More than 200 prominent Detroit industrialists, administrators and physicians gathered April 10 at a special Centennial Luncheon to honor the 100th anniversary of Harper Hospital.

Attending as special guests were representatives of industries, associations and organizations which were in existence in the Detroit area when Harper Hospital was incorporated by the Michigan Legislature in 1883.

Guest-of-honor and featured speaker was William Bean, M.D., of the University of Iowa Medical School, an authority on medical practice during the Civil War. Ray Eppert, president of the Burroughs Corporation and President of the Harper Hospital Board of Trustees, acted as official host. Dr. Eugene Osius, Harper Chief of Staff, was toastmaster.

Doctor Bean, in his address at the luncheon, said that in the absence of silk for suturing wounds and operation, some enterprising doctor used horsehair. But because the hair was stiff, the doctor boiled it.

"This not only made the thread suitable for sewing up wounds," stated Doctor Bean, "the boiling reduced the rate of infection, which was otherwise rampant, to nearly nothing."

Doctor Bean also stated that malaria took the lives of those who were not killed by gunshot. Again, by accident, a Civil War physician discovered that by mixing whiskey with quinine, the incidence of malaria fell off dramatically and soldiers returned to the line faster.

Doctor Bean reminded the Michigan audience that ours was among the first to have a medical school and laboratories. "Behind the great names at Harvard and Johns Hopkins," stated Doctor Bean, "was a not-so-famous but historically important Michigan medical school graduate."

The luncheon opened the Harper Centennial. Other events have included a news conference for 250 school children at the Hospital. On May 2 and 3 a medical symposium was held at the Wayne County Medical Society involving national authorities in the field of genetics and medicine.

Alumni activities occurred the first week of May, and the Centennial climaxed with a banquet at Cobo Hall, May 3, attended by approximately 1,500 friends of Harper Hospital.

The Patient Discharge Dilemma At the County Hospital

Edwin M. Smith, M.D.
Ralph L. Brandt, M.D., F.A.C.P.
Edith J. Brown, B.A.
Ann Arbor, Michigan

IN RECENT YEARS, the role of the county hospital, or Medical Care Facility as it is called in Michigan, has undergone extensive revision. Although virtually all the facilities in the state still provide permanent nursing care, many are also developing active, rehabilitation-oriented, treatment programs.[1] The value of these programs is illustrated by the fact that approximately 40 per cent of all the patients admitted to county hospitals can now become eligible for return to a non-nursing setting.[2] In the past, the number was closer to 5 per cent.[3]

The Dilemma

Despite this progress, the county hospital is still faced with the dilemma of how to return its rehabilitated patients to community living. Although many patients can be improved so that they no longer need hospital or nursing care, relatively few can be brought to the point where they can live by themselves.[4] The typical discharge candidate is in his mid-seventies, and retains the chronic disease that hospitalized him in the first place. Consequently, he still needs supervision, i.e. someone to see that he manages his affairs properly, has adequate meals, gets his shopping done, visits his physician, and so on.[5]

A surprisingly large percentage of discharge candidates lack family resources adequate to provide supervisory care.[6] Similarly, the community itself seldom has suitable placements. Room and board settings and homes for the aged are often unable to provide sufficient supervision, or they reject these patients altogether. Nursing homes represent a poor solution for the person who does not need nursing care. In many communities, the only alternative is to keep the patient in the county hospital itself. This is unfortunate because it not only clogs the hospital with custodial care patients, but it keeps these patients in an environment featuring invalidism and death rather than one emphasizing normal living.

Program at Washtenaw County Medical Care Facility

In recent years, the Washtenaw County Medical Care Facility, like so many other county institutions, has developed an active rehabilitation-oriented program. In the process it has also evolved a working mechanism for returning patients to the community. The ingredients of the discharge program are comprehensive planning and the utilization of an unusual community resource, the foster home. As a result of this program, 37 per cent of all patients admitted to the hospital have been discharged to non-nursing settings during the first two years of operation. This paper reports a survey of the program in terms of its specific features, the characteristics of the patients involved, and the fate of the dischargees once they have returned to the community.

The Active Treatment Program.—From 30 to 40 per cent of the 78 beds at the Washtenaw County Hospital are utilized by patients expected to benefit from active treatment. Medical care is geared to the resources of the facility. Patients with complex treatment and diagnostic problems are transferred to a general hospital. The objective of the medical program for each patient is to control his disease process, and to utilize his remaining resources in a manner which would permit his discharge to a non-nursing setting. A vital aspect of the medical program is use of physical restorative services designed to return disabled persons to physical independence, particularly in their mobility

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Doctor Smith is Assistant Professor, Department of Physical Medicine and Rehabilitation, University of Michigan, Ann Arbor, Michigan.

Doctor Brandt is Assistant Professor of Internal Medicine, University of Michigan; Cardiologist, St. Joseph Mercy Hospital; Medical Director, Washtenaw County Medical Care Facility.

Miss Brown is a foster home case worker, Washtenaw County Welfare Department.

TABLE I. DURATION OF HOSPITALIZATION OF PATIENTS DISCHARGED FROM THE WASHTENAW COUNTY HOSPITAL July 1, 1961-June 30, 1962

Duration of Hospitalization (Median: 3 months)	Per Cent
1 week or more	98
3 months or more	60
6 months or more	20
1 year or more	5
2 years or more	4

and personal care. The medical program is carried out by the nursing staff under the supervision of the medical directors, and the physical restorative program by a physical and occupational therapist under the direction of a physiatrist.

Table I indicates the length of hospitalization required by active treatment patients to achieve discharge status. The median hospital stay is three months, although 20 per cent require six months or longer. These figures serve to emphasize how essential is time itself to a successful outcome.

Characteristics of Dischargees.—Patients are considered eligible for discharge when: (a) their disease process is stabilized; (b) they are clear enough mentally not to require constant watching; (c) they are reasonably continent of bowel and bladder; (d) they are able to administer their own medications or treatments independently, or under the supervision of a lay person as directed by a physician; and (e) they are independent in their personal care and mobility. Wheel chair patients are considered independent if they can propel the chair and can get into and out of it without help.

The characteristics of such people can be judged from data collected on the 86 patients discharged to non-nursing settings between July 1, 1960, and June 30, 1962. As shown in Table II, their median age was 76, and 20 per cent were 85 years or older. Half of the dischargees were men, despite the greater proportion of women in this age group nationally. Table III points out the high incidence of neurological disease (47 per cent), musculoskeletal disease (42 per cent), and cardiovascular disease (42 per cent) in this group, although disease in virtually all body systems could be found to some degree.

The medications and equipment commonly sent with patients at the time of discharge are indicated in Table IV. During the period under study, analgesics were sent out with 30 per cent, digitalis preparations with 20 per cent, hypotensive agents with 15 per cent, and insulin with 7 per cent. Ten per cent of the patients were discharged with wheel chairs, and another 17 per cent required crutches or walkers. Six per cent wore a leg brace or prosthesis at discharge.

Discharge Procedure.—Because of the complexity of problems facing the discharge candidate, planning for him must be comprehensive. At the Washtenaw Medical Care Facility, much of the planning is carried out at regularly held discharge conferences. In attendance are the medical director, physiatrist, director of nurses, physical therapist, occupational therapist, program director, foster home case worker, welfare case worker, public health nurse and physical therapist.

TABLE II. AGE AND SEX DISTRIBUTION OF DISCHARGEES

Age Distribution (Median: 76)	Per Cent
Under 65	21
65-74	24
75-84	35
85 and over	20
	100
Sex Distribution	
Men	50
Women	50
	100

The purpose of the conference is twofold: to determine the eligibility for discharge of candidates, and to plan the actual placements. The capabilities and needs of the patient are enumerated, and those who could go to a non-nursing setting are considered for actual discharge. Family resources are then explored, and when inadequate, an alternate placement is considered. At the same time, referrals are made to appropriate agencies, e.g. the public health or visiting nurses, the visiting physical therapist, the welfare case worker, and a religious adviser. When the patient leaves the hospital, a case summary is sent to his personal physician and the agencies concerned.

TABLE III. MAJOR DISEASES OF DISCHARGEES*

Type of Disease	Per Cent
Neurological	47
Musculoskeletal	42
Cardiovascular	42
Genitourinary	16
Endocrine	15
Pulmonary	14
Special Senses	14
Gastrointestinal	14

*Some patients have multiple diagnoses.

Discharge Placements.—The family resources of the discharge candidates have generally been sadly limited. During the period under study, only 43 per cent had a living spouse or children, and in half of

these cases, the family could not provide the required supervision. As a result, only 22 per cent of the patients discharged to non-nursing settings could be returned to the care of their family (Table V).

Another 16 per cent were discharged to independent living situations, such as an apartment or their own home. These were primarily younger persons capable of living alone, thus their number was small.

For the remaining 62 per cent, the hospital utilized

TABLE IV. MEDICATIONS AND EQUIPMENT REQUIRED BY DISCHARGEES

Item	Per Cent
Medications	
Analgesics	30
Digitalis preparations	20
Hypotensive agents	15
Insulin	7
Physical Equipment	
Crutches or walker	17
Wheel chair	10
Leg brace or prosthesis	6

a program of foster home placement which had been managed by the Washtenaw County Welfare Department since 1954. The foster homes are operated by families willing to take in one to three older persons and provide them with the necessary supervision much as they would an elderly relative of their own. Normal living patterns and physical independence are emphasized in these homes, and when run properly they can provide the benefits of family life which a nursing home or custodial institution cannot offer.

Foster Home Program

Because the foster home program has proven so useful for the geriatric dischargee, it will be discussed in more detail. In a few communities, such programs have been employed for years, but experience with them in general has remained limited.

In Washtenaw County, there are 45 foster homes currently in operation. They have been recruited from a relatively broad socioeconomic spectrum, as is illustrated by the spread in monetary value of the homes themselves. Sixty-two per cent are valued at less than $12,000, 28 per cent are appraised at $12,000 to $17,000, and 10 per cent at $18-25,000. Thirty-two per cent of the homes are in rural areas.

The make-up of the foster families also varies. Forty-three per cent are comprised of three or four persons, while 49 per cent have only one or two members. The age of the "foster mother" is over 50 in 60 per cent of the cases. This reflects the fact that many of the homes are recruited from families having a room or two left vacant after their children have grown up.

TABLE V. DISPOSITION OF DISCHARGEES

	Number	Per Cent
Independent living	14	16
Foster home	53	62
Own family	19	22
	86	100

In Washtenaw County, the Welfare Department sets the standards for homes taking welfare recipients. A foster home case worker recruits and inspects the homes, makes the actual placements, and provides follow-up visits. In addition, her services are available for placing non-indigent clients (who constitute the majority of persons using the homes). The homes are also approved by the family physician if the dischargee receives Old Age Assistance funds, and by a public health nurse if the patient comes from the county hospital.

In selecting homes, buildings are utilized which have the appearance of a home, and which meet local fire and sanitation standards. The dischargee's bedroom, telephone, shower, and sink are preferably on the ground floor. When a wheel chair is necessary, doors must be wide enough and rooms large enough for adequate maneuverability, and there must be provision for safe passage to and from the house.

Members of the household are encouraged to treat the dischargee much as they would one of their own family. Ideally, the dischargee eats with the family, uses the living room to entertain, goes to church with the family, and is assigned limited household responsibilities. Thirty per cent of the families regularly take their wards with them on out-of-town vacations or overnight trips.

Success of a placement often depends on the skill with which the dischargee is "matched" to a foster home. The socioeconomic background, religious beliefs, personal habits, and psychological adjustment of both parties are considered when making the placement. An occasional "mismatch" is inevitable, but it can be quickly rectified by finding a new and more suitable placement.

Recruitment of foster homes has not been difficult in Washtenaw County. Most families hear about the program by word of mouth, although homes initially were located through church and service organizations, women's clubs, hospital auxiliaries and other similar organizations.

Payment to the homes by the Welfare Department varies between three and six dollars a day, and covers the cost of supervisory care and prescribed drugs. Additional payments are made when necessary for medi-

TABLE VI. ATTRITION DURING FIRST YEAR AFTER DISCHARGE

Died	19%
Returned permanently to hospital or nursing home	8
Total permanently leaving non-nursing setting	27
Rehospitalized temporarily	12

cal and dental services, appliances, clothing, et cetera. The income thus received has kept several of the homes from having to seek direct welfare aid themselves.

Foster home programs in general are not without problems. The definition of the foster home, of its function, and of the people it serves is not universally agreed upon. There are problems related to standards, inspection, approval, and the tendency for some homes to evolve into three-bed unlicensed nursing facilities. Difficulties may also arise in providing true family living and purposeful activity for the residents. However, the experience of the program in Washtenaw County has been that these problems can be solved. The most practical measure has proven to be assignment of a welfare case worker full time to the homes. She is in a position to enforce standards and to disseminate the philosophy of the program. Homes that are unsatisfactory are not used.

Attrition in the Discharged Population

When dealing with patients whose median age is 76 and who have one or more chronic illnesses, some degree of deterioration after discharge is to be expected. The experience with the 86 patients discharged from the Washtenaw County Hospital over the two-year period has not been discouraging, however. The average time elapsed since discharge for the group as a whole has been one year. During this period 19 per cent have died and 8 per cent have been reinstitutionalized or admitted to a nursing home (Table VI). Another 12 per cent have been rehospitalized temporarily, but have then returned to their non-nursing setting. Experience during the second year after discharge has been more limited, of course, but indications are that about 80 per cent of those staying out during the first year will also stay out the second year.

Advantages of the Discharge Program

The advantages of discharging patients from the County Hospital merit emphasis. The patient himself benefits by going from a hospital environment to one stressing normal living. The hospital benefits from the beds that are released and which can then be used for other patients requiring active treatment. The community benefits from the savings in tax money. It has been the experience in Washtenaw County that when the cost of maintaining each medically indigent dischargee in the community is subtracted from the cost of keeping him in the hospital, the gross savings to taxpayers is close to $1600 during the first year. When this figure is corrected for attrition among dischargees and for the added cost of the rehabilitation and discharge services, the first year's savings still exceed $1000 per patient.

Summary

With the introduction of modern, rehabilitation-oriented, chronic disease programs into the county hospital, a sizable number of patients are becoming eligible for discharge to non-nursing settings. The difficulty arises, however, in locating suitable placements for these geriatric patients because of their need for continued supervisory care. In Washtenaw County, lack of adequate family resources for many of the discharge candidates has led to use of foster homes as a substitute for family living. By utilizing these homes and by planning comprehensively, 37 per cent of all patients admitted to the Washtenaw County Hospital over a two-year period have been discharged to non-nursing settings. Sixteen per cent returned to independent living, 22 per cent to their own family, and 62 per cent to foster homes. Although the median age of the dischargees was 76, almost three quarters of the group were still in the non-nursing setting one year later. The net savings to taxpayers during this first year exceeded $1000 for each person discharged.

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Geriatric Patients in Michigan State Institutions for the Mentally Ill

A. H. Hirschfeld, M.D.
Detroit, Michigan

THERE ARE approximately 22,000 in-patients in Michigan's state mental hospitals. Of these, well over 6,000 (27 per cent) are 65 or over. The cost of maintaining these people is approximately twelve and a half million dollars per year. These figures are dwarfed, however, when it is considered that state hospital physicians tend to classify all people above the age of 55 in the geriatric category because of similarity in the treatment problems. If this were done, older patients in these institutions represent nearly half of the total census.

This paper reports a short survey made to determine something of their medical conditions and something of the problems affecting their care. More importantly, it is a report of these facts as observed by the physicians actually treating the patients. The attitudes of the physicians in attendance are particularly important because of frequent and justified criticisms of many presentations about the elderly "mentally ill." It is not infrequently pointed out that many theories about their needs and treatment are formulated without adequate experience. It is also said that solutions are idealistic because they are based on hopes rather than actual contact with the difficult clinical pictures really seen inside hospital walls. To avoid these errors, communication was established with each of the state hospitals (including Wayne County General Hospital, which has several thousand patients on contract from the state system). In each hospital, the contract was made either with the Medical Director, with the Chief of the Geriatric Service, or both.

First, a census was established, and this is formulated in Table I.

Principal Conditions Treated

The next question asked the geriatricians was what brought their patients to the hospital.

Philip Brown,[1] Superintendent at Northville State Hospital, said:

"The basic problem in our geriatric population is organic brain disease due to cerebral arteriosclerosis, and in the older age group due to senile changes. . . . With the age of this group of patients, of course, we have approximately one-third of them in our chronic medical ward for the treatment of such things as heart disease, diabetes, broken hips, et cetera."

TABLE I. CENSUS OF MENTALLY ILL PATIENTS

Hospital	Patients Over 64
Pontiac State	680
Traverse City State	600*
Wayne County General	1157
Newberry State	496
Kalamazoo State	1100
Northville State	650
Ypsilanti State	1168

*Over 70

Alexander Dukay[2] of Ypsilanti State Hospital said that his patients are hospitalized for chronic brain syndromes, functional psychotic reactions, psychoneurotic reactions, personality disorders and an occasional case of mental deficiency.

In addition to the problems of organic brain syndrome and arteriosclerosis, R. R. Cameron,[3] Medical Superintendent of Newberry State Hospital, says that 110 of his 496 aged patients "may have heart disease, peripheral arterial disease, varicose veins, pulmonary conditions, hypertension, diabetes, liver disease, arthritis, fractures of the hip and other bones, blindness due to cataracts and glaucoma, and deafness."

Custodial Problems

One of the principal objections to the use of state hospitals are the lyrical descriptions of long corridors

The Author
A. H. HIRSCHFELD, M.D.



Doctor Hirschfeld is a member of the Geriatrics Committee, Michigan State Medical Society; member of the Commission on Aging of the State of Michigan.

lined with patients who do nothing but sit and wait. Each hospital, accordingly, was asked how many of its oldsters really are primarily custodial problems.

Walter Obenauf[4] of Pontiac State Hospital says that about 40 per cent of his patients are primarily custodial problems. Brown[1] states:

"About 95 per cent of this group are custodial problems. However, two-thirds of the group are suffering from sufficiently serious mental disorders that hospitalization in a mental hospital is indicated. The other third are ones whom we feel, although certainly mentally ill, are not enough so as to require state hospitalization, and as above stated, we are gradually getting these patients outside of the institution."

The reference here is to an ongoing program by the State System to get these people back to their home districts.

At Kalamazoo State Hospital, Schrier[5] says, "Approximately 300 out of the 1100 patients are primarily custodial problems."

At Newberry State Hospital, "324 of these cases are primarily custodial problems," according to Cameron.[3]

Sidney Jenkins[6] of Wayne County General Hospital says, "We would roughly expect 40 to 60 per cent of these patients to be custodial problems."

Major Medical Problems in the Care of These Patients

Since morbidity is a major problem in people of this age, especially if they have difficulty caring for themselves or communicating with others, inquiry was made about their medical difficulties.

Dukay[2] says:

"Without any question, the greatest problem presented by these patients is the medical-surgical treatment required. More than 75 per cent of the geriatric patients admitted to the Ypsilanti State Hospital have, associated with the mental disturbance, a physical disability. In at least 30 per cent of these cases, the disabilities are of a serious nature such as uncontrolled diabetes, cardiac decompensation, general malnutrition, Parkinsonism, and sequelae of intracerebral hemorrhage or thrombosis requiring extensive medical workup, treatment, and intensive nursing care. To adequately handle these extensive medical problems is frequently a cause of irritation and frustration for our professional staff because of shortages of drugs, equipment, supplies, and nurses. . . ."

Cameron[3] agrees with him, saying:

"The major problems in care presented by the more chronic and severely ill patients involve chiefly general nursing care and medical care of chronic physical disease, with some senile dementia and psychosis with cerebral arteriosclerosis."

Suggestions for Improvement of Care by the State Hospital Physician

Each hospital was asked: "What general suggestions would you offer for improved care in this state?"

Dukay[2] answered:

"First of all, there should be a critical evaluation of the program already in operation and of the resources available on the community, state, and federal level.

"There is a critical need to establish training centers for convalescent and nursing home personnel to become acquainted with and efficient in rehabilitating the geriatric patient so he would not become a custodial problem.

"There is a great need for the establishment of modern, active, rehabilitative programs for the geriatric patients in existing mental hospitals so the patients could move into a half-way house or back into the community for sheltered or independent living.

"I believe in establishment of colonies, rooming houses with adequate medical and rehabilitative programs, sheltered workshops, and social clubs."

Obenauf[4] said:

"Putting emphasis on treatment and rehabilitation, rather than on custodial care, with the goal of returning patients home, or placing them in convalescent or boarding facilities. Therefore, there is need for an increased number of adequate facilities designated to take care of mentally incapacitated geriatric patients, as well as a need for after-care facilities for rehabilitating patients like:

"Hospitals for continuous care treatment, day and night hospitals, convalescent homes and boarding homes.

"Training of personnel in order to teach these people how to accept and to deal with mentally incapacitated geriatric patients."

Brown[1] said:

"Establishment of county operated convalescent homes with closed doors, and employes at least partially oriented in the care of individuals of this type. Were such an institution made available many of our beds now occupied by mentally ill geriatric patients could be changed to acute care psychiatric beds enabling us to treat younger and more prognostically hopeful cases."

Schrier[5] said:

"It is my belief that many of these cases could be taken care of in county hospitals if they had locked wards and adequate supervision could be given."

Local Programs

Following the above comments, each hospital was asked: "What, in your opinion, would be the main advantages or disadvantages of a more localized care program for geriatric patients?"

Schrier[5] answered:

"I feel that localized care programs would be very advantageous in most of these cases as they would be in partly familiar surroundings which would permit frequent visits from relatives and friends to keep them in contact with the community. When they are moved to state institutions, many times 100 miles away from their own home, it is difficult for friends and relatives to visit and they are completely lost."

Obenauf[4] said:

"Organizations of larger centers for diagnostic purposes and therapeutic recommendations would be important for adequate care of geriatric patients.

"However, continuous treatment should be given rather locally because of at least the following reasons:

"Geriatric patients, being less tolerant to changes, prefer to remain in a community closer to their homes and friends; local care would give family doctors opportunity to treat their patients and to continue therapeutic relationship with their patients; it would stimulate public interest in care and rehabilitation of their senior citizens through volunteers, citizens' groups, etc.; it would activate further planning for improved geriatric patients like boarding, jobs, recreation."

Dukay[2] said:

"Localized programs would help the geriatric patient to maintain his identity with the community, maintain his self esteem by not being thrown into a new completely unfamiliar environment of the state mental hospital. By staying in the community, the resources available in the community would be more efficiently mobilized and utilized.

"The great disadvantage for the localized programs for geriatric patients will be the tremendous energies required to overcome the initial inertia on the part of the community to change, the difficulties associated with the problems of adequate planning on the community level. The large initial cost and financial burden for the community to get a local program started which, however, would become in substance the more economical way from a long-range standpoint."

Conclusions

The reports of the men who are caring for the 6,000 aged mentally ill patients are uniform. There is general agreement that approximately a third of the patients now in Michigan state hospitals are suffering from what are really physical disorders. These are a very considerable problem to physicians in the state hospital system who are primarily trained in psychiatry. These problems are actually in the field of the internist or the generalist. At a time when the greatest problem in psychiatry is shortage of personnel, it seems remarkable that such a program should exist. Expediency would dictate that, except for training purposes, psychiatrists might well yield this group of patients to other medical specialists, in hospitals customarily equipped for their work.

The second major problem in the field of psychiatry at the present time is the need for beds in state mental hospitals. Here, again, the same problem arises. A large number of people whose greater problem is not mental illness, but a serious physical illness, are occupying psychiatric beds. Not entirely dissociated with this observation is that in the State of Michigan a majority of the people are covered by hospitalization insurance of one kind or another. Many would be entitled to insurance coverage if placed in private hospitals, or in general hospitals of various types, or even in nursing homes. Yet, when they are placed in the mental hospital with the primary diagnosis of mental disease, the State, and not the insurance company, is required to care for them.

The Department of Mental Health has itself been occupied with the problem of moving patients from psychiatric beds into community hospitals. In the last year more than 100 such patients were transferred from one hospital, and it is planned that in 1963 two hundred and fifty more will be removed. When these people suffer primarily from mental disorders, and not from physical problems, their main challenge is a matter of custodial protection. In fact, the main reason geriatricians suggest locked wards is the necessity of protecting confused people from wandering. It is quite possible to have open units in a facility which, however, has a guarded property entrance, so that no one will wander into danger while in a state of clouded consciousness.

Another observation of importance is Dukay's suggestion that federal and other considerations should be reviewed. It is a surprising fact that a majority of these patients are on social security, but that the social security payments do not come to the state hospital system. If these patients were placed outside of a state hospital system in colonies, or in minimum protective situations, much of their care could be paid from their own social security monies.

From a purely theoretical point of view, the basic assumption of state hospitalization for the majority of these patients is an absurdity. The things which make life possible on a level of suitable mentation for older people are the sense of usefulness, hope, and some feeling of love. The very fact of being faced with a large, relatively impersonal institution at a considerable physical distance from families, friends, and any part of a familiar environment is bewildering in itself and antithetical to known psychiatric principles of treatment. If the patient can be hospitalized, or partially hospitalized (as in convalescent facilities, or in

day hospitals, or night hospitals) near home where families and friends can visit, where volunteer programs are under way, a minimum of theoretical possibility of good treatment would be realized.

In addition to such theoretical considerations, there is much merit in Dukay's suggestion. A review of the federal concern in this situation shows that at the present time it is possible to build a three-room residence for older people which would cost approximately one-third of the price of one new hospital bed. Under other federal regulations, convalescent homes also can be built for a similar price. If such facts are made known to the public, some of the initial inertia referred to by our correspondents might quickly be overcome. It appears that the possibility of running such facilities for older people *at a profit* is sufficiently good to invite a great deal of investment over the nation as a whole since this legislation was enacted.

Summary

In summary, it may be said that 6,000 older people are occupying beds in the state hospital system of the State of Michigan. Of this number a third are quite seriously ill physically and should have local and better non-psychiatric care provided them. Another two-thirds are primarily custodial problems, and many of these could be cared for in local, more hopeful facilities which would be more suitable on a basis of psychiatric theory. For such people, it would appear that their removal from distant unsuitable beds would relieve the state hospital congestion and free psychiatrists to give psychiatric treatment to people, who, as Brown says, are prognostically better risks. Properly administered, such a program even carries the hope of reduced state expenditure, through better use of health insurance, social security money, private capital, and available federal funds.

Nursing Homes Double Capacity Since 1954

Although a shortage of skilled nursing care homes exists throughout most of the Nation, such facilities have almost doubled in their capacity since the first nursing home inventory in 1954.

A recent survey finds that since 1954, skilled nursing care homes have increased in number from 7,000 to 9,700, or 39 per cent. Their total capacity has nearly doubled—from 180,000 beds in 1954 to 338,700 in 1961. Practically all of these beds—337,300—were reported as assigned to skilled nursing service. Infirmaries or facilities having personal or residential care as their primary purpose account for an additional 24,900 skilled nursing care beds, bringing the total such beds available throughout the country to 362,200.

Nonhospital facilities in the United States and Possessions which provide nursing or supportive services to chronically ill and aging persons now number 23,000. The resident capacity now totals 592,800, a 32 per cent increase over 1954's total of 450,000.

When classified according to their primary type of service, the 23,000 homes are broadly grouped as follows: 9,700 skilled nursing care homes; 11,100 personal care homes; and 2,200 residential care facilities.

The survey further showed that approximately 87 per cent of the skilled nursing care homes are owned by proprietary interests.

The survey shows that skilled nursing care homes are larger than they were about a decade ago. The average size today is approximately 25 beds as compared to 19 beds in 1954.

The Proprietary Nursing Home

Frank W. Marsh, A.B., L.P.N.
Grand Rapids, Michigan

THE PROPRIETARY nursing home has been a counterpoint of civilization since its inception. Primitive at first, its recompense, a haunch of venison, a bear skin, a bow and arrow, and so on to the present, always conforming, always pacing the changing panorama of our advancing culture. This constant advance has caused change. This change has caused a separation, then, from the established practices of the past.

Our pressing task, then, is the need to recognize change and cope with it. Much change is not necessarily new, because it has never before existed but because it has changed in quality. The recognition of change calls for the marshaling of our resources, the courage to face the challenge, a definition of motivation and goals.

Private industry has been and always will be the backbone of a free country. It is a concept of our United States. Its precept is the rendering of service for profit, a proper balance of which makes for a dependable culture.

Our goals are the "needs." What we need is what we can use effectively. What we can use effectively depends upon our "know-how," enthusiasm and aggressiveness. I have said that one of our needs is "know-how." The proprietary nursing homes in years past have formed an organization in Michigan known as the Michigan Nursing Home Association, one of whose purposes is the vehicle to provide the nursing home administrator and staff, knowledge and training. Working closely with our schools and universities, our state and local health departments, through committees, classes, and many workshops, much has been accomplished in the field of general nursing care, restorative rehabilitation, personnel training, plant management, and uniform accounting, all of which have been improved a great deal. Liaison has been established with other groups having to do with the chronically ill.

Mr. Marsh is a past president of the Michigan Nursing Home Association and a member of the Michigan Joint Council to Improve the Health Care of the Aged.

Concepts of the Proprietary Nursing Home

Let us study for a moment the various concepts of the proprietary nursing home as envisaged by the various segments of our present-day culture, in care of the aged.

The Political Concept.—This is the parental image, bathed in the golden glow of millions of votes, for here is a voting group which will have the best that public money will buy, whether they need it or not, or whether the money can be efficiently spent. To say this image is biased does not necessarily condemn it, for all images are biased, seen from individual viewpoints. The political image has produced much research and study, has focused attention upon the aging population, the para-medical groups and the nursing homes, in particular. It envisages a sterile institutional structure, into which the aging group is funneled in an atmosphere entirely foreign to its normal environment; effective, but destroying the very basis of freedom of choice, which is the American heritage.

Concept of the Aging Group.—These are the pioneers who through the years have carved, often from the wilderness, a niche, from which they have directed their own lives, reared families, contributed in many ways to their country's success. These are the folk who have been telling others what, where and when, to do. Seemingly, their view of a nursing home is a place of their own choosing

(a). Where a measure of security can be enjoyed, where former associations are not all removed, where they can still be a part of life as it goes swirling around them;

(b). Where they are assured of the good nursing care that is needed, in a cheerful home-like surrounding;

(c). Where the cost is adequate but fair;

(d). Where, "Blessed is he who looked away when coffee was spilled at the table today."

We must recognize that this group is becoming more and more articulate.

The Public Concept.—The public image of the nursing home is perhaps the most conservative of them all, and yet practical. It conceives a nursing home in the community and a part of the community. It recognizes the nursing home as a separate entity of its own, apart from, yet closely allied to, the general hospital, giving a service of good nursing care to the patient, in economical home-like surroundings under the supervision of the patient's personal physician. It abhors the institutionalizing of a nursing home as breaking the chain of independent living. It is critical, because of past history, but being itself a proprietary group, recognizes the ability of the proprietary nursing home group to police itself and provide through competitive practices the remedial steps necessary.

Are these images in conflict? To some extent yes, but the common denominator to our way of thinking is "nursing care," commensurate with the "need." This will not call for a nursing home providing a glorified cure-all in one package because of the economic factor, but there must be a diversification of homes, providing a diversification of services. This, in the spirit of free enterprise, must be on a voluntary basis, not a legislated one. This, of course, pre-supposes diversification of needs, for you cannot have one without the other, and this evaluation would be the sole responsibility of the patient's personal physician.

In some respects, this diversification is good, for the nursing home offering these specific services would be staffed and equipped to give them. On the other hand, this would cause an imbalance of patient load in the skilled care facility, necessarily increasing the cost because of the increased staff and making it economically impossible oftentimes for the improved patient to remain.

While there are many advantages to this plan which offset some of the disadvantages, some advances in this direction have been made, in spite of the time-lag, in new construction, in training administrators and staff, in acceptance of new concepts of care. Briefly, then, the proprietary nursing home of the future will not be a place of last resort; it will be a place between the hospital and the patient's home, a place where restorative procedures are available to the patient with some rehabilitative potential, a place where well-trained native ability will be offered, a place where people will be wanted, loved, and accepted, a center of activity in the community, conveniently accessible for visitation.

The greatest forward step for nursing homes in Michigan was the transfer of licensing to the State Health Department in 1957, where we were most fortunate in having a very competent, understanding and cooperative State Health Commissioner in the person of Albert E. Heustis, M.D. The problem of establishing a program of rules and regulations which would be a basis of guarantee of good nursing care for the chronically ill was worked out jointly by the commissioner and the Michigan Nursing Home Association. This listing of the basic requirements for plant, staff and equipment was designed so that nursing homes would meet them on a progressive basis over a period of five years. While a goodly number of nursing homes in the state were in the main already meeting these requirements, there were many points where the expert knowledge of the Department could be utilized. Classes and workshops for administration and staff were established in the various regions of the Michigan Nursing Home Association, where accurate information could be given, where an exchange of ideas and adaptation could take place. As a result, some of the rules and regulations were modified and some were expanded. At present, a six-week course is being offered to nursing home administrators at Michigan State University, East Lansing. The George Washington University is offering a two-year graduate course in nursing home administration.

There were and still are many economic problems to be overcome. It was found that more professional nursing care would cost more. It was found that plant changes were costly. It was found that investment funds were almost unavailable.

There was the question of which should come first —better, more professional nursing care or increased charges to provide that care. The first and most desirable would mean investment capital. Where would this come from? A nursing home building is of necessity a one-purpose building, and investment sources consider this type of building a poor risk. First progress in this direction came from the Small Business Administration which offered short-term loans for plant expansion and improvement, but the still low per diem payment for patient care made the short-term loan impractical. Through initial efforts of the American Nursing Home Association, of which the Michigan Nursing Home Association is a member, the Federal Housing Administration (FHA) offered long-term loans for new construction, renovation or expan-

sion. This, coupled with the need for more nursing home beds and showing the confidence of Government in nursing homes, gave the private lending agencies the proper incentive, until today capital is available in practically all parts of Michigan. In the past three years, in Michigan, 70 new nursing homes have been opened and 2,072 new beds have been added.

A voluntary system of accreditation and/or listing of nursing homes is being implemented at the present time in Michigan. This means that the individual nursing home thus accredited or listed thereby indicates the type of service for which it is staffed and equipped. Proper medical records are maintained, particularly in the field of daily nursing records. Through better doctor-nursing home relationships, more complete records of doctor's orders and progress notes are kept. Drug records are complete, and standards equipment is provided.

The Michigan Joint Council to Improve the Health Care of the Aged, composed of representatives of the Michigan State Medical Society, Michigan Hospital Association, Michigan State Dental Association, and Michigan Nursing Home Association, has played a vital role in Michigan by helping to identify and analyze the health needs of the aged, by appraising available health resources and developing programs to foster the best possible health care of the aged, by encouraging the expansion and improvement of health care facilities.

The future, of course, is what we make it, for we are at the "growing edge." We must remember that the proprietary nursing home and the challenge have more points in common than we have in disagreement, that we should seek more unity of action, not more uniformity of action, remembering that freedom must be accompanied by responsibility.

Frequent Problems to be Aired at AMA Meetings

The latest information on some of the most common problems that confront physicians will be presented at eight general scientific sessions during the annual meeting of the American Medical Association in Atlantic City, June 16-20.

Heart attacks, strokes, cancer, peptic ulcer, heredity, obesity, venereal disease, and painful back will be covered in lectures or panel discussions.

A series of lectures on modern concepts of acute myocardial infarction, including basic physiological and pathological considerations, will be presented by Jesse E. Edwards, M.D., St. Paul, Minn.; *Richard J. Bing, M.D., Detroit*; Jack W. Crowell, Ph.D., Jackson, Miss.; Carleton B. Chapman, M.D., Dallas; *Franklin D. Johnston, M.D., Ann Arbor*, and *Thomas N. James, M.D., Detroit*.

A day-long symposium on strokes is scheduled on Wednesday, June 19.

The question, "What Drugs for What Cancers by What Doctors?" will be answered June 19.

A full day's program will be devoted to a symposium on newer knowledge and therapy of peptic ulcer on Monday, June 17.

A panel discussion on medical genetics will bring together David Y. Y. Hsia, M.D., Chicago; *Harold F. Falls, M.D., Ann Arbor*; Maurice T. Fliegelman, M.D., Louisville; E. Burke Evans, M.D., Galveston, Texas, and David C. Fainer, M.D., Baltimore.

Various problems associated with the treatment of obesity will be explored by a six-man panel June 17, and also an analysis of the painful back.

Dental Services for the Aged

Andrew C. Pringle, D.D.S.
Detroit, Michigan

THERE is a definite need for dental services among the aged. This need is strikingly obvious among patients over 65 who are confined to their homes, nursing homes, hospitals and homes for the aged.

A visit to the dentist years ago was, at best, a trying experience, and older people in institutions have a tendency to look back 25 years or more to some uncomfortable experience in a dental chair. But now, with the great advance in dental techniques, high-speed cutting instruments and new drugs, the visit to a dental office is a pleasant one with very little discomfort.

The older people would like to prolong their lives and have a happy existence. They often do not know, however, that poor oral hygiene and missing teeth lead to poorer health and *unhappy* living.

A study in nursing homes of Mississippi has shown a profound lack of dental care among elderly residents.[1] The chronically ill and aged were observed in the area of Kansas City and presented about the same needs as the Mississippi group.[2] In May, 1962, the Dental Division of the Michigan Department of Health visited nursing homes and homes for the aged to obtain basic dental data on the institutionalized aged of Michigan.[3]

The prevalence of poor oral health was determined in the survey made by the Michigan State Health Department (Dental Division) of Nursing Homes in the State of Michigan. Twenty-three institutions in the state were visited by four dentists and two dental hygiene consultants of the Michigan Department of Health and three dental health officers of the Public Health Service. Periodontal, operative, exodontic, surgical and prosthetic needs were observed in 1,244 residents, who also were noted as to treatability, acceptance of care, mobility and source of income.

Report of Survey

1. Median age of the survey population was 81.5 years.

2. The population consisted of 72.4 per cent of women and 27.6 per cent of men.

3. Dental services were needed for 63.3 per cent of the men and 49.3 per cent of the women.

4. Prosthetic services were needed by 44.5 per cent of the residents.

5. Nine per cent of residents needed instruction in cleaning of dentures, but this figure does not include the possible potential of total usefulness of a dental hygienist in a dental program for the aged.

6. Extractions were indicated for about 23 per cent of the men and 9 per cent of the women. The mean number of teeth for extraction per man in need was 8.14; per woman, 6.00.

7. Less than 5 per cent of the residents had satisfactory and intact upper and lower natural dentitions with no need of any prosthesis while nearly three-quarters (73.2 per cent) of the men and three-fifths (60.6 per cent) of the women were completely edentulous or needed extractions of all remaining teeth.

8. Seventy-eight of the appliances which were worn by the residents were satisfactory. Nearly 30 per cent of the edentulous arches required a new denture. The number of edentulous jaws illustrate the necessity of prevention, control and education in early and middle life.

9. Of the total population, 64 per cent were treatable and receptive to care. One-half of the group with need of a dental service were of such characteristics in comparison to three-quarters of the group with no need of care.

10. Seven-eighths of the residents were transportable and could be moved to an outside center.

11. More than one-half of the group had a private income and more of this group were receptive to dental care than those of the group who received public funds.

Generalizations

The following statements are generalizations based mainly on the Michigan survey and on some considerations in part from the other studies. The similarity

Doctor Pringle is a member of the Michigan Joint Council to Improve the Health Care of the Aged.

of the data of the Michigan survey to other studies encourages and may validate such generalizations. Although the measurements may be crude observations, generalizations seem warranted when three different examining teams observed three different samples of elderly persons and arrived at nearly the same quantitative assessments.

At first glance, it would appear that a large volume of dental care is needed for an elderly population. Over one-half of the aged would need treatment. Prosthetic care is comparatively expensive and would be needed by 45 per cent of the group. Twenty per cent would need both an upper and lower denture. However, before hands are raised in despair, perusal of the data may show indications that the problem is not overwhelming. Certain factors of reducing the caseload appear:

It would be folly to attempt to treat that portion who would be untreatable and resistant to care. Further, it would be frustrating for the dental practitioner who uses his skills to produce a satisfactory denture, only to find that the denture will not be worn in the mouth but will remain out of sight and without function in a drawer. Therefore, if only the treatable and receptive to care aged are considered, it is possible to reduce the needs to slightly more than 25 per cent of the population.

Another survey, *but of the questionnaire type,* was made in Detroit under the sponsorship of the Detroit District Dental Society.[4] A questionnaire was sent to 150 institutions in Wayne County asking for a simple *yes* or *no* to the questions. The number of residents in these institutions approximated 2,637 people. The owners or managers of the homes answered the questions.

Report of Survey

1. Do you have any facilities for dental care? *Three* answered *yes, forty* answered *no.*

2. Do you have any provision for outside dental care? *Twenty-four* answered *yes.*

3. Do you feel the need exists for dental care? *Thirty-six* answered *yes.*

4. Do you require an oral examination on admission? *Thirty-three* answered *no.*

5. Would your institution cooperate with the Detroit District Dental Society if assistance were available for diagnosis and treatment? *Forty-three* answered *yes.*

The surveys presented here indicate the need for dental care. They indicate the ability to pay in a majority of cases. In Wayne County, possibly because a questionnaire was used, 43 of the 150 institutions showed interest in cooperating in a dental program.

The Michigan State Health Department (Dental Division) has procured two portable dental kits and a portable dental x-ray machine. These portable kits are small but complete and practical dental operatories packed in a case weighing not more than 30 pounds. The kits can be borrowed by any dentist who has to do operations in institutions or for any patients who are not ambulatory.

It has been reported to the Michigan Joint Council to Improve the Health Care of the Aged that the dentures of patients in institutions are continually getting mixed up. This problem can be obviated by placing the owner's initials in the denture or some other suitable identification. This may seem to be a trivial matter, but to the patient it is a serious situation.

At the 15th Annual Conference on Aging, held June 18-20, 1962, at the University of Michigan, it was pointed out that approximately three-quarters of the 17 million persons over 65 years of age owned their own homes. Many of the remaining 3 to 4 million have private insurance or private income. For those really in need of assistance, there is the Kerr-Mills Act. In Michigan, this is called the "Medical Assistance for the Aged Act." This act does not specifically provide for dental care. However, an effort is being made to amend the act so that it includes dental services.

Summary

There is a need for dental services and for dental health education in institutions for the aged.

There is money to pay for these services, both from private and public sources.

There is the manpower to do the job.

There is new and modern portable equipment available.

The Medical Assistance Act for the Aged should be amended to provide for dental services.

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Social Forces and the Management Of the Alcoholic Patient

Henry Krystal, M.D.
Detroit, Michigan

For the want of a nail the shoe was lost,
For the want of the shoe the horse was lost,
For the want of the horse the rider was lost,
For the want of the rider the battle was lost,
For the want of the battle the Kingdom was lost,
And all for the want of a horseshoe nail!

MOTHER GOOSE RHYMES

ON SOME of our major highways, billboards advertise that "Alcoholism Is Our Number Three Public Health Problem." To over five million Americans and their families, alcoholism is the Number One health and life problem. One in every eighteen Americans is afflicted with alcoholism. An alcoholic suffers for ten to fifteen years from the self-destructive process of the alcohol addiction before he loses his job because of his absences, damages and irresponsibility. He may then "hit bottom" and ask for help. The financial damages we suffer as a nation from alcoholism run into astronomical figures which, however, fade into insignificance in comparison to the human misery involved, the slow but inevitable destruction of the patients, the damage to the emotional stability of their spouses, and the often irreversible emotional damage to their children.

Alcoholism represents one of our most serious national health problems. One wonders why, in this country in which we were able to mobilize gigantic social forces in order to impose the constitutional amendment enforcing prohibition, these forces are not available for the treatment and prevention of alcoholism. The lesson of the prohibition era is clear. Forces are tied up in the consumption of alcohol which, when damned up by prohibition, threaten to demoralize our society. We cannot prohibit or give up the use of alcohol. The alcoholics, therefore, are the victims of this indispensable social evil. The discrepancy between our need for and fear of alcohol, and the weak and ineffectual action we have been able to muster in the aid of its victims, is a measure of the potent, yet unrecognized paralyzing influences at which we want to take a close look today.

We have never been able to approach the problems of alcoholism with either the determination or the unity of purpose which marked our attack on other public health problems or prevalent diseases. We have never organized a uniform public drive on a voluntary basis to aid the research and treatment of this common problem. The state government-sponsored programs in this area, which we shall examine in some detail, are found wanting in a number of essential respects.

The problem of alcoholism is as old as civilization. All indications from prehistory, through archeological studies, suggest that wherever civilization was established, alcohol was part of the ceremonies, rituals and observances. Alcohol may have been one of the factors that made civilization possible.[1] Alcohol was the original miracle drug: the original anesthetic, tranquilizer and aphrodisiac. Men on their own, and armies, as a matter of policy have used alcohol to dull their fear and enhance their courage. Alcohol helped control men's aggression. When most of men's natural enemies were eliminated, men's aggression turned against their own species, and had to be tamed to preserve civilization. Obviously, we haven't mastered that drive as yet, nor can we be sure that we ever will. Civilization requires the renunciation of a great many natural impulses of men. Alcohol has always been used to help dull one's drives and allow the necessary conformity. As the inhibitions imposed by civilization often became excessive within many individuals, preventing drive discharge, alcohol has been used to mollify one's conscience and allow some pleasurable activities. Next to narcotics, alcohol is still the most effective drug for the relief of depression.

No wonder that a drug of such potency (and availability) became interwoven in the very matrix of every aspect of civilization. All of the great religions deal with alcohol in their theologies and historical or mythological traditions. But even in the same religious

Read at the semi-annual meeting of the Michigan Association of Alcoholism Programs, March 22, 1962.

From the Wayne State University College of Medicine Department of Psychiatry.

teachings, one can find evidence of conflicting and unresolved attitudes, considering alcohol at once the devil's tool and God's gift to suffering mankind.[1] The Bible, for instance, implicates alcohol in many wrongdoings of man, beginning with the incestual relation between Lot and his daughters. The opposite attitude is reflected in Proverbs, 31:

> "Give strong drink unto him that is ready to perish, and wine unto those that be of heavy heart . . .," and
> "Let him drink and forget his poverty and remember his misery no more. . . ."

These mixed emotional attitudes towards alcohol have been intimately related to the history of the problem of alcoholism and have not been resolved to date. The relatives of the victim of alcoholism are likely either to overprotect him or to condemn and reject him. Those who condemn his drinking, even if they are tee-totalers, often unconsciously contribute to his difficulties and have a stake in his remaining a drunkard. The authorities, both secular and religious, are likely to judge rather than to be able to help a problem drinker. Lacking the knowledge of the underlying emotional problems which are basic to the addiction to alcohol, they may show a holier-than-thou attitude and all too often, after exhausting the professional charity, and frustrated by the alcoholic's recalcitrance in the face of well-meant incantations and exhortations, they may fall into threatening or punitive attitudes. A small but significant group of clergy has been able to help many alcoholics through their intuitive perception of this problem and their own limitations.

Psychotherapeutic work with alcoholics, in the last sixty years, especially through the utilization of the tools of study provided by psychoanalysis, has advanced our knowledge of the underlying emotional problems in the problem drinker. Alcoholics do not suffer from the same emotional disorder, but share a method of self-medication with alcohol.[2] Alcohol, while on the whole safer, less toxic and less addicting than most of the newer tranquilizing drugs, can cause serious damage to the organism. With constant overindulgence, accompanied by poor nutrition, liver, brain and other organ damage ensues.[3] However, as has been pointed out by many, especially K. Menninger, the self-destructive problem is inherent in addiction, and is manifest in the patient's life consistently in many areas. Many alcoholics would destroy themselves sooner without alcohol.[4]

The emotional problems of alcoholics result in the production of a state of chronic depression and anxiety in them. Alcohol lends temporary relief from those very painful states, allowing fairly normal function for many people for long periods of time. The alcohol, however, fails to arrest the self-destructive problem involved. The medical profession as a whole has never felt quite at home with addiction unless it could be proven to be a physical disease. This failing, most physicians prefer to limit their role to the treating of the physical complication of alcoholism, recognizing that most doctors are not trained to treat psychotherapeutically the underlying emotional problems of the alcoholic. Unfortunately, many of them confuse this role with the treatment of alcoholism *per se*, which they are not doing.[2]

On the whole, psychiatrists are reluctant to treat alcoholics. One important cause of this resistance is that in the treatment of most alcoholics, one needs to employ a number of therapeutic assistants. The psychiatrist, in private practice who tries to treat the alcoholic patient on a solo basis, usually meets with failure and becomes discouraged about his ability to help the addicted patient.

The psychiatrist skilled in psychotherapy, when treating the alcoholic, also has practically a full-time job on his hands of recognizing and dealing with his own emotional responses to his patient. In order to remain capable of helping the problem drinker, he must be able to recognize when he is experiencing anger and frustration with the behavior of his patient, lest his anger turns him against his patient and drives him to judging or overprotecting the alcoholic. That the alcoholic is driven to provoke such responses in everyone around him becomes part of the tragedy of his life. At last he alienates all those dear to him and the long descending spiral of guilt and self-destructive activity drives him to death, sometimes via jails, hospitals, "skid rows" and poorhouses.

Such massive misery and self-destructive life trend are hard for anyone to bear. It is most frightening of all to acknowledge that we too share such impulses. We find it more comfortable to label the alcoholic "weak," "degenerate," or simply "bad."

These mixed emotional responses have crept into the national fabric of all our efforts to help the problems of alcoholism. Alcoholism, however, is not an isolated example in our tendency to develop prudish and hypocritical responses to social problems which we do not like but are not ready to eliminate. We have, for instance, similar attitudes towards gambling and prostitution. While most people object to these activities, continuing to condemn and outlaw them,

some of the most vociferous objectors may secretly enjoy both at times, either in a surreptitious participation or by vicarious experience. The reason, of course, that even those who do not gamble or patronize prostitutes may enjoy reading descriptions of "vice-cities" or watching movies about "saintly" prostitutes or "noble" gamblers is related to a variety of unfulfilled yearnings expressed in these social institutions. Our inner conflicts resulting from the failure to recognize consciously that we cannot, at present, do away with these social evils results in a variety of ways of rationalizing our ineffective action. Even though we know that our present way of handling these problems has resulted in the creation of a powerful crime organization, we are helpless to do anything about it. We are driven to find scapegoats for our guilt in this area periodically however, and after we express our righteous indignation by an investigation or even jailing a gangster, we fall back into inactivity.

The United States and the Soviet Union are among the most puritanical and prudish cultures of our day. In relation to alcoholism, both countries show a strong prohibitionist and punitive trend. In the Soviet Union, for instance, an alcoholic is considered to have a "social disease," and is likely to be sent for rehabilitation to a work camp.[5] In the United States, we talk a lot more about "the disease, alcoholism," but the bulk of problem drinkers, whenever they come to the attention of their community, end up in jail anyway. One Michigan judge, active in the field of alcoholism, expounded on the need for more alcoholism education with the flair of an orator. When, however, he was asked why he had not referred a single problem drinker in the preceding year to the alcoholism clinic in his community, he observed, rather baffled, that he "had not seen any alcoholics in his court lately—just drunks."

Thus the good judge, by a convenient split in his mind, considers the alcoholics sick, the drunks bad—but as he never sees any "bona fide" alcoholics, he can proceed to practice primitive vengeance. The courts are not alone in this. A whole school of Soviet psychiatry has been developed on the basis of time-honored practices patterned after our reactions to thumb-sucking. Old-wives' tales advise to cure thumb-sucking by putting evil-looking and tasting stuff on the thumb. In pseudo-scientific psychiatric practices, the same procedure dressed up in fancy language is called aversion therapy or conditioned reflex therapy. Since the Sputniks, our envy and admiration of our Soviet counterparts has encouraged the adoption of these Pavlovian practices to a greater degree in the United States.[6]

What is wrong with such an approach is that it contributes to the alcoholic's already serious problem of self-punishment and self-destruction. This attitude ignores the fact that the problem drinker has an underlying emotional illness, but treats him as a naughty child, punishing him for his over-indulgence. Prompted often by our envy of his lack of restraint, lack of self-discipline and his determination to enjoy things which we have had to renounce, we feel that the alcoholic should be punished, and that a "swift kick in the pants" is just the thing he needs for his own good. Thus under the guise of treatment we give vent to veiled punitive attitudes.

In most of the states, an attempt has been made to organize some sort of an alcoholism program. In some, as California, these have budgets exceeding a half million dollars annually. In other states, the programs are younger and less adequately endowed. In Michigan, for instance, there is a fund set aside for financing a State Board of Alcoholism, with the upper limit of 5 per cent of the state's income from the alcohol license fees, about $200,000. The budgetary allowance, in addition to setting aside this sum of "conscience money" from the alcohol trade for the rehabilitation of its victims, was hamstrung by providing that it be administered by the state legislature, and by a six-man lay board. The Michigan legislature ignored the fact that, in 1957, the California Board for Alcoholism Rehabilitation was found unworkable and replaced by a professional administration.[7]

State alcoholism offices as a rule concentrate on alcohol education and on stimulating local activities by matching local funds for alcoholism centers, which are conceived as carrying out alcohol education as well as the treatment and rehabilitation of the alcoholic patient. These alcoholism boards, however, have run into a good deal of confusion and turmoil. Local organizations and public health agencies have learned to accept state and federal funds, but the matching fund was harder to find. By a clever maneuvering of budget figures, it is possible to "appropriate" services, such as light, heat and rent for rooms and salaries of personnel already otherwise assigned or occupied, and in this way to obtain state funds. However, if the state policy provides for a gradual decrease of the state support, sooner or later the local bodies have to put up some hard cash or close up the clinic. Thus, clever and devoted public health officers, who can sell the idea of starting an alcoholism program to their boards of health or city councils on the basis of the good old

"gimme," by convincing their local agencies that they will get something-for-nothing, eventually get caught in a trap of their own making. Unless the government, local and state, is aware that the treatment of alcoholics is a difficult and expensive operation, these activities must eventually wither for lack of funds and support.

Yet the clamour to pretend that the alcoholic can be cured cheaply and quickly, and thus the pressure to "sell" the programs to those who control the purse strings as a cheap one, continues unabated. This is perpetrated by people who really know that the treating of an alcoholic is a long, difficult and expensive process. Their wishful thinking prevents them from carefully examining the statistics available and confronting themselves with the bitter truth contained therein.

The greatest confusion of all became apparent in relation to the question of the functions of the alcoholism centers and the qualifications of the personnel to be employed in them. The reason that the alcoholism boards of many states have failed in this respect is understandable in terms of the history of our attitudes and knowledge about alcoholism. In the past, even ten years ago, only judicial and religious authorities were concerned with the alcoholic, albeit for reasons other than his own welfare. The American psychiatrist was slow in assuming his responsibility in relation to the alcoholics, thus creating a void that had to be filled. This void was filled by the Alcoholics Anonymous, an organization dedicated to self-help and a mutual program for maintaining abstinence between problem-drinkers. Alcoholics Anonymous has been singularly successful in its program based on quasi-religious and group therapy activities.[8] It has now close to a thousand chapters throughout the United States and its membership is estimated at 200,000, or 4 to 6 per cent of the total alcoholic population. There remains, therefore, a substantial group of 4.8 million alcoholics who for a variety of reasons cannot accept this type of an approach, and another five to ten million people, the close relatives of the alcoholic, who often are emotionally disturbed, and so involved in the problems of the alcoholic. At least one other person has to be treated along with each problem drinker if the patient is to have a fair chance to succeed. The relatives, it should be noted, are *not alcoholics,* but show a variety of emotional problems.

When the various states started to stimulate the opening of alcoholism clinics, the problem of staffing the clinics became a major one. There are now some one hundred and twenty clinics in the United States devoted to the treatment of alcoholism. However, here we use the word "clinic" loosely. As there were no clearly set precedents, some of the solutions to the personnel problem depended on the political structure of each state. In California, for instance, the authority to supervise the alcoholism program was given in 1957, to the Division of Alcoholic Rehabilitation of the California State Department of Health.[7] Such a structure tends to promote the adoption of training norms and standards comparable to the State's Division of Mental Health. In some states, however, like Michigan, an entirely independent body was set up to supervise this program, in this case a State Board of Alcoholism. The Board had neither the background nor the inclination to start its work by defining the roles to be played in the clinics by various disciplines and to set up or adopt the state's standards for the qualifications of people who may treat the alcoholic patient. Instead, while preaching that alcoholism is a disease and treatment of the problem is required, it allowed all local groups to organize any type of "clinic" with any type of program, employing personnel with any background or training and often without any preparation. Any handy white-collar office worker, nurse, college graduate with a bit of education or sociology background, was hired for the job. A Michigan Board official stated recently that he felt one must start with "the best you can get and try to improve or replace it . . . to lend an ear and support to any type of program, treat them equally, and let the professionally staffed program prove its superiority."[9]

Contained, however, in this reasoning, is, as recent events have shown, spurious logic which in effect destroys the value of the whole program because of the original negligence. As in the Mother Goose rhyme, the whole kingdom is lost for the want of a horseshoe nail. Once the Board of Alcoholism proceeds on the assumption that anyone can treat alcoholics, they plant in their program the seed of its own destruction. For they can never justify to the legislature two types of treatment, a "cheap" unprofessional one, and an expensive professional program. Unless the legislature is confronted with the difficulties and realities of treatment of the alcoholic, it is bound eventually to insist on the exclusive use of "cheap" treatment, which has been sold to them as adequate.

The recent study of the Rockefeller Foundation has shown that local agencies which derive part of their support from community-chest funds or other local financing, once established, become entrenched and unmodifiable. One alcoholism clinic, which has a director with a background in sociology, but innocent

of any knowledge of psychiatric diagnoses or treatment, has found it impossible in the last several years to retain professional personnel. On two occasions, psychiatrists were influenced to take the job of clinical director of the above agency by the local University. In each case, however, they ran into rigid, unmodifiable controlling attitudes of the non-medical "executive director" supported by the board of that institution. At least one of them resigned for this reason alone.

The problem of the deployment of ex-alcoholic Alcoholics Anonymous members as therapists presents an especially touchy problem. Many of them feel that they can best help the alcoholic since they have been "through it" themselves. This feeling is justified by experience *as long as they function within the framework of the Alcoholics Anonymous.* But if a person untrained in psychology, social work or psychiatry starts acting as a "counselor" with the alcoholic, he is not only unprepared for the job but in a much worse position to deal with the alcoholic. For he has many "sensitive spots" in his own make-up which make him especially susceptible to untoward reactions to the alcoholic. He is likely to turn vengeful, or become excessively involved in the problems of the patient, and be driven to act in ways which are harmful to himself and his "patient."

The untrained personnel have unwittingly become involved in a statistical sham and self-deception. Unaware of all the complexities of the problem involved, they soon get to feel that they have a "special talent" for psychotherapy. They come to expect that they can "cure" an alcoholic by one good talk with him. One Michigan "clinic" published a follow-up study of their patients in which they apologized that they had to see "some patients" more than once. If the patient does not return, he is assumed to be cured. Thus the State Board received reports from unprofessional "clinics" reporting a high rate of cures after a single visit, and from professional clinics which may spend as many as ten hours with the patient for psychiatrist, psychological and social work studies, before they even have a conference to decide on the best management of a case. Then the professionally staffed clinic is likely to have the patient in treatment for two, three or more years, and have to provide treatment for his family as well. It is inconceivable that an administrative board would confuse the meaning of such diverse reports and treat them on par. Yet this is exactly what happens in Michigan, and in other states as well. Viewed against the background of our national confusion and conflicting attitudes toward the alcoholic, we must conclude that this gigantic blind-spot in the Board's evaluation of these pseudo-clinics is due to the board members' unwittingly engaging in wishful thinking. Tragically, they are simultaneously expressing hostility toward the alcoholic, of which they are not conscious. Accepting the reports of professional clinics and amateur counselors on an equal basis, in effect sabotages the aim which they profess to work for.

The Michigan State Board was recently driven to reap the fruits of its policies. It has withdrawn support from a small but excellent alcoholism clinic in Highland Park, Michigan, stating that the treatment there was "too expensive." The Board recommended that the clinic modify its operation to provide "cheap treatment" as is given by a non-professional person in a nearby community. That "clinic" does not even profess to do treatment but calls what it does by that ambiguous term, "alcoholism information." Thus the Michigan State Board has demonstrated the absurdity of its own policy of allowing all types of "clinics" to function and prove their true worth "in competition."

Thus is revealed that the condemning "kick in the pants" attitude reigns still in the Michigan State Board of Alcoholism, as it does in many other states. The old excuse that there are not enough psychiatrists (or social workers or psychologists), is nursery-rhyme logic. We can now discover the truth behind the do-gooders' tendency to sell alcoholism education rather than treatment for alcoholics. Alcoholism propaganda is cheap. A thousand leaflets can be printed and distributed without pain or strain to anyone. But when facilities are not available to treat the alcoholic, of what good is alcoholism information which is mainly directed to say: "If you are an alcoholic, seek treatment"?

The alcoholism information activities have a function comparable to that of a zero in arithmetic: only when another figure stands before it does it have any value. Without available treatment, alcoholism information activities are a sham. They serve us to pretend that we are doing something about the problem, in order to appease our conscience. But we want it done easily and cheaply. If the alcoholic needs a lot of care and help, then, "he is a drunk, a degenerate, and he should go to jail."*

*A quest for the cheap and easy cure is nicely described in an old advertisement quoted by Dr. William J. Stapleton in a recent issue of the *Detroit Medical News* from the *Detroit News Tribune*, 9/11/1900: "Morphine and Opium Habit Cured at Home—week's treatment free, painless and permanent. Write in confidence or call personally. Tack-a-Pou-Sha Treatment Co., New York." I have the distinct feeling that the State-sponsored Board would even now like to have its alcoholic patients cured by a later-day Tack-a-Pou-Sha company.

The tragedy in the lives of our five million precious individuals suffering from addiction to alcoholism is that they would be the last to protest against such mistreatment. Their whole problem is based on a deep-seated conviction that no one wants to or can help them. They like to go to a "clinic" where no help is available, and to have to go back to alcohol feeling justified that they tried to get help. The way some of our State Boards are acting, one wonders whether there isn't some truth in the feelings of alcoholics that alcohol may be bad, but it's the best friend they have found yet.

In conclusion, then, we must observe that the widespread difficulties preventing our alcoholism programs from becoming effective stem from the deep-seated cultural conflicts related to our attitudes toward alcohol, and even more basically towards the victims of the very forces that shape our society. The alcoholic stands for a variety of "sins" we would prefer not to see in ourselves. He is a scapegoat whom we would much rather forget. Thus "alcohol education" for a long time must concern itself not only with the victims of alcoholism, but with all of our population, from whom will come the power and the authority to undertake prevention, treatment and research in this area.

Unless the legislators, and other individuals in authority, are aware that the rehabilitation of the alcoholic is a long, difficult and expensive process, the workers in the field who venture to try it under inadequate conditions will be blamed for the failures of the programs. Alternate excuses that there are not enough psychiatrists must be dealt with by the recognition that for the most part the conditions for adequate treatment have been set up only rarely, and therefore we failed to attract adequate personnel. Above all, the educational process that is needed must be concentrated upon the knowledge that the alcoholic, troublesome, sickening or difficult as he may be, is the victim of civilization. He is one of those unfortunates who carries the burden of civilization on his shoulders.

As we have not been able to design a society which does not produce alcoholics, we owe it to them to rehabilitate them. As it happens, rehabilitation is cheaper, in the long run, than the deterioration we allow to take place at present. Alcoholism is one of the emotional problems which requires a group approach, i.e., the treatment of the patient in a clinic. Only the development of enough professionally staffed clinics for the treatment of all alcoholics will be an adequate response to the problem.

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Medical Maxims

Promotion of general health is more important in multiple sclerosis than specific therapy.

Bone pain following a bout of sneezing suggests a destructive bone lesion.

One should be cautious in making a diagnosis of neurosis in any patient over 40 years of age.

In brain tumor the neurologic signs follow a slowly progressive unremitting course.

Because of the frequency of epilepsy in the chronic alcoholic, concussion or skull fracture from falls should be suspected when such patients are confused or unconscious.

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Children's Services and the New York Community Mental Health Law

Marvin E. Perkins, M.D.
New York, New York

THIS meeting today is most timely for a consideration of community mental health legislation. I understand the legislature of the State of Michigan has a measure of this type currently under review.[1] For me to discuss the merits of the bill pending here would be presumptuous, to say the least. On the other hand, you may find of some interest an account of the seven years experience which we have had with the New York State Community Mental Health Services Act of 1954.[2]

Whether this type of legislation would be good for the State of Michigan, the City of Detroit, other municipalities and the less populous counties of both peninsulas must be determined locally, of course. I can report to you the effects in New York City upon the development of mental health services under the New York State Act. In the time allotted me, I can give only a few glimpses of what we have seen develop. I shall give a brief resume of the background for the New York State Act; a short summary of the powers and duties of a mental health board; a view of one problem encountered under the Act; an overview of psychiatric services extant during the most recent year for which statistics are complete; some budgetary facts pertaining to the same year; and some recent developments in children's services, made possible under the New York City Community Mental Health Board.

Let me emphasize two facts which are important to an understanding of the New York City Community Mental Health Board as an agency of the government. First, the Board and staff together comprise an agency of *local* government and *not* a part of the vertical organization of the state's mental hygiene department. Second, the New York City Community Mental Health Board is *not a part of any agency*, but is an independent element with its own unique responsibilities.

Presented before the annual meeting of the Children's Center of Wayne County, Detroit, Michigan, March 14, 1962.

Doctor Perkins is Commissioner of Mental Health Services, New York City Community Mental Health Board.

The New Era

On December 1, 1954, a new era began in the history of the care of the mentally ill in New York City. On that date the City Charter was amended to establish the New York City Community Mental Health Board to serve as the responsible staff agency for mental health services.[3] This action implemented the State Act, passed in 1954 by the State Legislature. The Act was an outcome of a five-year study made by a special commission, established in 1949, under the chairmanship of the New York State Commissioner of Mental Hygiene.[4] Other members were the State Commissioners of Social Welfare, Health, Education, and Correction.

Their study documented the chaotic and inadequate condition of local mental health services throughout the state. No locality had sufficient psychiatric services. Services that did exist were not well integrated. Outpatient services were particularly in demand; and expansion of inpatient services in general hospitals was sorely needed. In no community was there a single governmental agency responsible for central coordination, supervision, and planning. The limited state funds available for mental health were being disbursed to communities through several state departments with little or no regard to local planning. The Commissioners concluded that if community mental health programs were to be developed soundly there would have to be a specially created, single local governmental agency in each community to act as the central responsible body. Local governments undoubtedly would need sustained financial aid from the state. The aid would need to be channelled to one local governmental agency so that expenditures could be based on sound community planning.

Provisions of New York State and City Laws

On the basis of the Commissions' findings and recommendations, the state act was designed "to encourage the development of preventive, rehabilitative,

and treatment services through new community mental health programs and the improvement and expansion of existing community services." To accomplish this, the act provides for financial aid to communities which establish mental health boards in accordance with certain provisos.

In conformity with the enabling legislation, the local law which established the New York City Community Mental Health Board was enacted by the city's legislative bodies. The law requires a nine-member Board. Two members, the Commissioner of Health and the Commissioner of Welfare, serve exofficio. Seven members are appointed by the Mayor. At least two of the appointed members must be physicians actively engaged in private practice. Appointed members serve for terms of four years without compensation. The Mayor designates one of the members as Chairman.

The nine-member Board is empowered to appoint a psychiatrist to serve as the Director of Community Mental Health Services. The Director, as chief executive officer of the Board, employs and removes officers, employees and consultants as may be necessary for the work of the board.

The powers and duties assigned under the local law to the Board and the Director may be summarized as follows:

To review and evaluate community mental health services in the city;

To submit to the Mayor a program of the needed mental health services and facilities;

Within the amounts appropriated, to carry out the program through: Agreements, approved by the Board of Estimate, with other appropriate city agencies for the rendition of services and the operation of facilities; Contractual arrangements with other agencies, approved by the Board of Estimate, for services and facilities essential to a community mental health program.

To make rules and regulations concerning the rendition of services and the operation of facilities supported wholly or partly by tax money;

To provide general supervision to these services and facilities.

The state act designates four types of mental health services as eligible for state reimbursement: outpatient clinics, inpatient services in general hospitals, rehabilitative services, consultative and educational services.

The original state act made provision *for the state to reimburse 50 per cent of the net expenditures of a city or county government made through its community mental health board.* The concept of 50-50 sharing between state and local governments, however, was restricted by the provision, "that the total state reimbursement shall not exceed an amount equal to one dollar per capita for the population. . . ." Although this limitation was written into the act merely as a gauge to measure projected state costs, it erected a "ceiling" which no community was expected to reach for at least a decade. The architects of the law were soon to realize the error in their estimate.

The provision seemed ample enough. Under the original ceiling of $1.00 per capita of population, New York City, according to the 1950 census, could be reimbursed annually by the state up to $7,878,009. In other words, the state could legally meet 50 per cent of the city's approved expenditures through the Community Mental Health Board up to $15,756,018.

The Ceiling Problem

The city's appropriations for the New York City Community Mental Health Board, which were increased each fiscal year, soon exceeded the amount eligible for 50 per cent reimbursement by the state under the original ceiling. This was largely because the local appropriations for existing municipal psychiatric services and the imminent expansion of these services had not been realistically taken into account in setting a specific amount per capita as a limit on state aid.

Already by 1956-57, appropriations for the Board—$15,848,926—exceeded the ceiling on state reimbursements by almost $100,000. During the next fiscal year, 1957-58, the appropriations, which totaled $19,445,487, were approximately $3,700,000 over the ceiling. In 1958-59 almost $4,000,000 of the appropriations, which had increased to $19,716,234, were non-reimbursable. In 1959-60, the city's total appropriations for the Community Mental Health Board—$20,462,045—were approximately $4,700,000 in excess of the amount eligible for 50 per cent reimbursement by the state under the limitation of $1.00 per capita of population.

In part because of the lag in state sharing, expansion of the city's program came practically to a halt during 1958-59 and 1959-60. Aggregate increases in local appropriations during these two years—approximately $1,000,000—had to be used mainly to meet the rising operational costs of the psychiatric units already in the Board's program. During those two years, only one additional psychiatric clinic was opened in a municipal hospital and only one additional contract with a voluntary agency was executed.

The question was clear. In the financing of a program, established jointly by the city and the state, should the state's share be anchored while the city's share steadily increases?

Through the concerted efforts of interested and informed citizen groups and legislators, bills were introduced into the 1960 session of the State Legislature to eliminate the ceiling. Although these efforts fell short of the goal, they did succeed in having the limitation on state reimbursement raised to $1.20 per capita of population. The "ceiling" had been raised, not eliminated. The new ceiling made potentially available to the city an additional $1,575,610 in state reimbursement funds for the fiscal year 1960-61. Expansion of the Board's program once again became possible.

The issue of a per capita limitation on state aid for community mental health programs is far from resolved. The New York City Community Mental Health Board considers the removal of the limitation the urgent "order of the day." Further development of the city's mental health program commensurate with the great need for expansion of psychiatric services depends to a large degree upon remedial legislation under which the state would match funds with the city on a straight fifty-fifty basis.[5]

Overview of Psychiatric Services in New York City

A few facts and figures point out the extent of psychiatric services in New York City during 1960 by municipal and voluntary agencies. The proportions of services provided through the Community Mental Health Board show the significance to the city of the program.

By the end of the year, there were 130 licensed clinics operating within the city. Thirty-two were municipal, ninety-eight voluntary. Fifty-five of the voluntary clinics were under contract with the Board; all thirty-two of the municipal clinics were by agreement between city agencies in the Board program. This means that eighty-seven clinics, or 70 per cent of all the clinics in the city, were in the program during 1960, either fully or partially supported by the funds provided through the Community Mental Health Board. A total of 112 clinics of the 130 licensed clinics served children; and more than two-thirds of these were in the Board's program.

On March 31, 1960, about 81,100 patients were on the rolls of all clinics. Of this number, 86 per cent were on the rolls of the clinics in the Board program. Approximately 60 per cent of the total were on the rolls of municipal clinics and 26 per cent were on the rolls of contract voluntary clinics. Only 14 per cent of the patients on the rolls of all clinics were not under the Board program!

The same situation is observed in the tabulation of admissions, terminations, personal interviews and professional man-hours. There were some 47,200 admissions to all clinics. The clinics under the Board's program drew 88 per cent of total admissions. Municipal clinics drew 66 per cent and the contract-voluntary agencies 22 per cent of the total number of admissions. Approximately 39,700 cases were terminated by all clinics. The Board's municipal and contract-voluntary clinics provided 89 per cent of the total. Terminations in municipal clinics were 27,100 or 68 per cent of total terminations and in the contract-voluntary clinics, 8,100 or 21 per cent.

In all New York City clinics, over ¾ of a million personal interviews were held by professional staff with patients, or, with other persons about patients. Of these interviews, about 75 per cent were held in municipal and contract-voluntary clinics. Approximately 44 per cent of the total interviews were held in municipal clinics; and 31 per cent were held in the contract-voluntary clinics.

Professional man-hours in all clinics totaled over a million and a half. The Board's municipal clinics and its contract-voluntary clinics each utilized 39 per cent of all hours. Thus, the eighty-seven clinics in the Community Mental Health Board program utilized 1,327,700 or 79 per cent of the total professional man-hours spent in all of the 130 licensed clinics in the city.

All of the facts presented above refer to the outpatient clinic portion of the Board's program. A substantial part of the program provides in-patient services in general hospitals. In fact this is the greater part of the program. The number of psychiatric beds in general hospitals in the city, both municipal and voluntary, totaled 1,359 at the end of the year. Of these beds, 1,213 are in municipal general hospitals and 146 in voluntary general hospitals. By agreement with the Board, payments are made to the latter for hospitalization of medically indigent psychiatric patients.

The 1960-61 Budget

How were state, city and voluntary funds arrayed in support of the psychiatric services of the city? At the end of calendar year 1960 the Board's total 1960-61 budget was $22,937,563, of which state funds made up $9,453,610, or 41 per cent of the total budget; city tax levy funds $12,284,722 or 54 per cent; and private funds of contract voluntary agencies, $1,199,-231 or 5 per cent.

On the same date, December 31, 1960, allocations were: to other city agencies, $18,249,748 or 79.6 per cent of the total budget; to voluntary agencies,

$3,493,972 or 15.3 per cent; and for administrative costs of the Board, $380,063 or only 1.6 per cent. This shows the heavy engagement by local government in mental health services, a fact not generally recognized; a fact, the ignorance of which, led to the error in the "ceiling" estimates in the beginning.

Voluntary Services

Having described something of the commitment of the city and state governments to the Board's program of services, I would like to turn attention now to the smaller part of the program: the voluntary agencies and their services. Of interest will be the process by which contracts are developed under the reimbursement provisions of the basic law. Some recently added contracts will illustrate the range of interest of the Board in establishing children's services.

The expansion of voluntary psychiatric services, both out-patient and in-patient, is, of course, of utmost importance in the development of the city's mental health program. Operating under flexible conditions, voluntary agencies often are able to pioneer new ways to provide needed psychiatric services. Under certain circumstances, they can move more quickly to fill gaps in the community program than can municipal agencies. Furthermore, with governmental funds available through the Board, voluntary agencies can help the municipal psychiatric services carry their heavy patient loads.

Out-Patient Contract Negotiations

The negotiation of each contract—new, renewed, or amended—involves extended consultations between Board staff and key persons in each agency. On the basis of these consultations, the Director submits to the nine-member Board a written statement containing his recommendations based on a description and evaluation of the agency's services. An evaluation contains pertinent information on the agency's auspices, organizational structure, policies, finances, and services, as well as detailed information on the plans for improvement and expansion of services, including cost figures. If the Board approves entering into contract with the agency, a contract is drawn up and recommended to the Board of Estimate for adoption, subject to approval by the State Department of Mental Hygiene.

A contract, as a rule, covers salaries and other specified costs of certain phases of an agency's service. In some cases, an agency's entire program is covered by contract. The total contract amount, figured on a yearly basis, represents specified estimated costs of the services, minus a percentage of estimated fees from patients.

Early in 1955, the Board set a policy, which was reaffirmed November, 1960, that an agency be asked to provide one half of the total contract amount. If the Board determines that an agency is unable to provide half of the contract amount and deems the proposed or existing services of paramount importance to the community mental health program, the Board may recommend to the Board of Estimate that city tax levy funds be allocated to the extent needed for the contract. Thus, a contract may have attached a schedule showing agency, city and state funds in various proportions.

The Contracts

At the end of 1960, four new contracts had been executed making forty contracts with voluntary agencies in effect. Thirty-seven of these were with agencies providing out-patient clinical services, two with rehabilitation agencies, and one with a community center to provide mental health consultation services to the center's various divisions.

Of seventy-four voluntary agencies in the city operating licensed out-patient clinics, thirty-seven were in contract with the Board. Fifty-five clinics were operated by our contract agencies, out of a total of ninety-eight licensed voluntary clinic offices in the city.

The distribution is city-wide. Five of the clinic offices of the contract agencies are in the Bronx, fifteen in Brooklyn, twenty-seven in Manhattan, seven in Queens, and one in Richmond.

All age groups are served. Three of the contract clinics serve adults only. Fifty-two serve both children and adults. Among these fifty-two contract clinics are six out of the eight clinics in the city providing specialized services for children: two of the six contract clinics serve seriously disturbed children and their parents; four, mentally retarded children and their parents.

New Developments

One of the four new contracts negotiated in 1960, that with the Kennedy Child Study Center, Inc., allowed an expansion in the center's specialized services for retarded children. Two other new contracts furthered the development of day care programs for disturbed children. These were with the Godmothers' League, Inc. Day Treatment Center and School, and the League School and Research Center.

The fourth new contract in 1960 was with the Montefiore Hospital for Chronic Diseases, Inc. This

contract covered an expansion in out-patient services, a necessary step in the development of the hospital's new program of comprehensive psychiatric care. Arrangements were also made for the payment for treatment of medically indigent patients in the hospital's new psychiatric in-patient unit. The Board's effort in community psychiatry, of which the Montefiore program is a good example, will not be developed here.

Specialized Services for Retarded Children.—The Kennedy Child Study Center established in 1958 under the auspices of the Catholic Charities of the Archdiocese of New York, provides diagnostic and therapeutic services integrated with a day-time developmental and training program for severely retarded children from four to seven years of age, and casework services for their parents.[6] In addition, the center accepts some children for speech therapy only. Diagnostic and referral services with parent counseling are also provided for children not acceptable for treatment in the center because of extreme emotional or physical handicaps.

The day care program is particularly significant in that it is geared to a crucial period in the life of a severely retarded child, the years between four and seven. During these years, it becomes possible for the first time to work with these children in groups. Since a severely retarded child has great difficulty with the simple fundamentals involved in relationships with others, group experience, as early as possible, is essential to his development. With patient and painstaking care many children develop sufficiently to go on to school, either in special classes for the retarded or in classes for normal children.

Budgetary limitations had prohibited the recruitment of a full staff and prevented the relatively new quarters of the center from being used to capacity. It was estimated that the center, if fully staffed, could serve about seventy-five children in the day care program. Instead, because of staff shortages only about forty-five children could be enrolled. The other services were similarly limited. The contract was drawn up to provide the necessary personnel to expand all services to capacity. The total contract amount for expansion was $73,628, half of which amount represents state and half private agency funds.

Day Psychiatric Care in an Educational Setting for Emotionally Disturbed Children.—The Day Treatment Center and School of the Godmothers' League provides a program of psychiatric care in an educational setting for children who cannot attend school because of emotional problems.[7] Children between five years-eight months and eight years of age are accepted. The prognoses of these children are hopeful. With proper treatment they can go to public or private schools within two or three years.

The program consists of two parts. The first is the day school program in which a child spends his day with a teacher trained in child development. The child is treated by a psychiatrist or psychiatric social worker, depending upon his needs. The parents are always involved in either individual or group therapy with a member of the clinical staff. The second part of the program is the aftercare services. Once a child has progressed from the day care program and is attending school, the clinical staff continues to work with him and his parents for about three years to insure continued progress. During 1960, twenty-four families were in the day care program and fourteen in the aftercare services. About seven families each year move from the day care program to the aftercare program.

The Godmothers' League established its present day care program in 1956 when its shelter program for babies was discontinued in recognition that foster home placement of infants was preferable to agency care. On July 1, 1957, the State Department of Mental Hygiene made a six-month grant to the league to aid in developing the new program. The agency also discussed contractual arrangements with the Board. Until the program was in full operation, costs and fees could not be figured closely enough for contractual purposes. In view of this, the Board suggested to the Department of Mental Hygiene that the state grant be continued. This was done. The league received a yearly grant of $20,000, which terminated on June 30, 1960. The 1960-61 contract between the Godmothers' League and CMHB was negotiated to continue and further develop the services provided under the state grant, particularly the aftercare services. The total amount of the contract was $40,008. Half of the amount comes from the state and half from the voluntary agency.

Non-Hospital Psychiatric Services for Seriously Disturbed Children.—For many years in this country, the primary resource for seriously disturbed children was the state institution. A few private residential centers were available. The care given was more often custodial than therapeutic. Persons interested in the welfare of these children began to seek other solutions. One result of these efforts was formation of the League School and Research Center, which opened in Brooklyn in 1953. The school provides a community-based treatment and education program for seriously dis-

turbed children. Children from three to fourteen years of age are accepted.[8,9]

The school reports much can be done for the child whose prognosis once would have been considered hopeless. Since the school opened, seventy-four children have been enrolled. Twenty-nine of these have been discharged. Eighteen of those discharged have made definite progress. Eleven have gone on to public or private day schools. Two children had so improved by the time they were fourteen that they could be enrolled in a special day school for children far less disturbed than those accepted by the League School. Five are in residential centers, and two of these are being trained for gainful employment by the New York State Division of Vocational Rehabilitation. Of the other eleven children discharged, one died, two were withdrawn, and eight had to be placed in state institutions.

Contractual arrangements with the Board were first discussed in 1958. However, the psychiatric clinic of the school was not licensed until July, 1959. Hence, only then did it become eligible for a contract. By that time the Board had no funds available for new contracts. When a demonstration grant of $20,000 a year from the State Department of Mental Hygiene (commenced on July 1, 1956) was due to terminate on June 30, 1960, a contract was negotiated to maintain the services developed with the aid of the state grant. The total amount of the contract is $40,000. Here, too, half of the contract amount is derived from state and half from the voluntary agency.

Discussion

One result of the 1954 state and local legislation in New York was the establishment of a system which encourages state-local participation by means of the local agency, the Community Mental Health Board.

When the encumbrance of the $1.00 per capita limitation upon State Aid was modified in 1960 by legislative action, the Board in New York City was able to enter into new contracts for children's services. The Board chose to support three agencies whose work is along the frontier of work with children: specialized services for retarded children; day psychiatric care in an educational setting for emotionally disturbed children; and non-hospital psychiatric services for seriously disturbed children.

The services were contractually established under New York City authority. A combination of financial resources of the private agency and the state were merged through the efforts and approval of local government.

Before the enabling mental health legislation was in effect, such state support of the assumption of responsibility by local government was not possible. Assumption of wider ranging responsibilities by local government has become possible with provision of fiscal support under the Community Mental Health Services Act.

Local government thus has become a significant factor in the arrangements for new and improved services in the community. Having been given the responsibility, local officials are increasingly cognizant of needs, more fully responsive to demands and progressive in approaching new service requirements for children.

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MICHIGAN DEPARTMENT OF HEALTH
ALBERT E. HEUSTIS M.D., State Health Commissioner

Nursing Homes and Homes for the Aged—Progress Report

In 1956, the Legislature transferred statutory responsibility for the licensing of nursing homes and homes for the aged from the Department of Social Welfare to the Michigan Department of Health. In the intervening seven years, the state health department, with the aid of local health departments, has worked in close cooperation with these homes to help assure better, safer care for many of our older people. While the intent of the statute is primarily regulatory, the main thrust of the licensing and consultation program has been educational.

Shortcomings

Initial visits to nursing homes throughout the state revealed shortcomings in many homes, including lack of adequate nursing coverage, poor food service, carelessness in the handling of drugs, poor patient records, lack of understanding of older patients, and general problems related to sanitation and safety. There were needs for a new set of regulations for licensure, for continuing in-service training of nursing home personnel, and for rehabilitation efforts.

An Interim Committee on Nursing Homes was established which approved Rules and Regulations which were adopted as part of the administrative code. These provided for a 15-member Commissioner's Advisory Committee on Nursing Homes and Homes for the Aged to advise on the administration of the law and rules.

Members included home administrators, local health department representatives, nurses, physicians, members of religious-fraternal organizations, and representatives of the public.

Rules and Regulations

Of the 252 rules and regulations adopted, only 136 were enforced as of January 1958 with the remainder to be enforced at later assigned times. This approach was made with the full cooperation of the nursing home leaders and allowed for an orderly and progressive pattern of improvement. Under the law, homes could have provisional licenses for three years, but all homes were urged to qualify for full licenses as rapidly as possible.

Beginning in 1958, efforts to upgrade nursing home care were intensified and, in the past five years, a number of training and rehabilitation programs have been started. Two training films for nursing home personnel have been produced by the department; a Food Service Guide has been published to give practical information on food buying, storage, preparation, and service; seven centers for training nurse-aides have been established under the provisions of the Manpower Development Training Act; rehabilitation evaluation clinics and rehabilitation workshops have been conducted; and consultants from the state and local health departments have continued to work with nursing homes to help improve patient environment and care.

Beds Up—Homes Down

The gross record shows that the number of nursing homes and homes for the aged has decreased from 600 in 1957 to 531 in 1962.

However, in the same period, the number of beds has increased from 13,429 to 18,724. This has occurred while the number of rules enforced has increased from 136 in 1958 to 200 in 1960, to 209 in 1961, and to 245 in 1962. Thus, it is apparent that many of the smaller, poorly equipped homes could not meet minimum health rules, and that the trend today is toward the larger, better equipped, better staffed, better run home.

Even so, under the pressure of the increase in the rules from 136 enforced in 1958 to 245 enforced today, the percentage of homes qualifying for full licenses has dropped from 69 per cent (80 per cent of the beds) to 61 per cent (67 per cent of the beds) in 1962. Most of the homes not now fully licensed either have provisional licenses or temporary permits to let them make the specified corrections. Some are due for reinspection and have pending licenses.

Today, with all but seven of the rules originally developed being enforced, the licensing program has completed its initial stage of development. Much remains to be done to help homes improve, but definite progress has been made.

Home Is Important To Aged Patient

By Jack Rom, M.D., Member,
MSMS Geriatrics Committee

The ideal way of life for the aged person is that which allows him to live in his own home or in a setting as much like his home as is possible in which he may continue to feel comfortable, secure and useful and to participate in family and community life. When, for health or various socio-economic reasons, this becomes impossible, transfer to one of various types of institutions may become necessary.

Institutional living for the aged must provide for more than the physical needs of the individual and this is being more fully recognized with the increased understanding of the needs of the elderly. This was aptly stated by Dr. Vlado Getting, one of the members of the Michigan State Medical Society's Geriatrics Committee, who wrote*:

> In measuring the provisions which should be made in institutions for the care of the aged, it is well to keep in mind their total needs. Like all people, older individuals, need it be stated, require love, security, shelter, food, and clothing. Provision must be made to keep them occupied as well as to learn group living in recreational programs. Religion often plays an important part in the lives of older people. They may require more medical care, more drugs, more prostheses, more attention from physicians and dentists, and longer periods of hospitalization than persons under 65 years of age.
>
> Public institutions for the aged have paramount responsibilities that go beyond the basic provision of food, clothing and shelter and the care of their ill. For every potential resident the first step is a clear determination of needs; surveying the community for a solution rather than bringing him into the institution is a second important step. If it is determined on further study that there are no suitable facilities available and that the person's needs can be met best by institutional care, then a careful plan should be developed as to how to meet the individual's need best in a custodial plan.

That physicians of the Michigan State Medical Society may obtain a broader view of some of the facets of institutional living for the aged, the Geriatrics Committee has been happy to plan this present number. It is hoped, with this issue, to give the readers of THE JOURNAL a greater insight into the care of the aged in institutions and into some of the problems and challenges that arise therefrom.

Pennsylvania Medical Journal, Vol. 60, March, 1957.

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What More Can We Do, Doctor?

By Mrs. Ross V. Taylor, President,
Woman's Auxiliary to the Michigan State Medical Society

The main purpose of the Woman's Auxiliary to the Michigan State Medical Society is to aid the state and county medical societies in promoting the objectives of the profession. We obtained our birthright from the Michigan State Medical Society and we look to you for guidance. Two basic matters seem urgent at this time. One is our auxiliary membership and the other is your personal health.

We need a strong auxiliary membership working by the side of our doctors in joint service. The present membership is only about half our potential. We would urge you to use your influence to have an auxiliary for every organized medical society and to have all of the wives of every member of the Michigan State Medical Society members of the Woman's Auxiliary to the Michigan State Medical Society.

The auxiliary is proud of its accomplishments to date. We have worked for the medical societies in many fields and in many ways. In recent years our efforts have been concentrated on legislative activities to help preserve the best system of medical care in the world. We are becoming active in politics at the request of the AMA. Our program is ever expanding. Two years ago we added Rural Health. This year we added International Health Activities. Since World Medical Relief is located in Detroit we have an unusual opportunity to be of service to a world wide medical community.

Last year we contributed over $11,000 to AMEF. This year, our contributions to AMAERF are expected to exceed that amount. This money has been obtained by a variety of projects and activities. We are working in Health Careers Recruitment to relieve the great shortage of doctors and para-medical personnel.

We know too many physicians are overworked and we are concerned that too many doctors are dying too young. We would like to help you to preserve your health. You doctors are not getting for yourselves the medical care which you are giving to your patients. You are not getting the routine complete check-ups to help keep yourselves well and too often you seek medical care only when some condition is acute. Your colleagues are pleased to have the opportunity to care for you, but you are not giving them that opportunity. If "professional courtesy" is a contributing factor to the lack of proper preventive medical care, or whatever other reasons, it behooves the medical societies to do something about it. The auxiliary cannot aid you in this. You are very much needed and you can only continue to give care to your patients if you care for yourselves. "Physician Preserve Thy Health!"

More Must Be Awakened

By Donald E. Wood, M.D., Chairman,
AMPAC Board of Directors

Thousands of physicians and their wives all over the country have already accepted the challenge of political action. They passed their first test in the 1962 elections with flying colors, and now with their initiation behind them, they've enthusiastically taken up the task of preparation for the campaigns of 1964.

An optimistic sign? We at the American Medical Political Action Committee (AMPAC) certainly think so. But we know too that there is another side to the coin. If the PAC movement is to achieve maximum effectiveness in 1964, thousands of others in the medical profession must be awakened to the need for their participation in political activity. It is no longer enough to "let George do it." The ever-present medicare issue has taught us that.

If medicine is to remain free, doctors and their wives in increasing numbers must continue to unite in strong and knowledgeable

support of candidates who share their point of view.

More is involved here, however, than merely the addition of names to the membership rolls of AMPAC and the state PACs. The doctors and doctors' wives who choose to accept their political responsibility should set themselves two goals: to acquire a good basic education in the ways of politics and to become active in their state PACs and in the party of their choice. AMPAC itself is developing two political education courses geared to the medical profession, the "Barnstormer" and "Volunteers for '64."

Becoming active within the state PAC and the party organization is another matter. Here, the physician's own interest and his political "book-learning" will be invaluable to him. But most important will be his willingness to work. Indeed, this willingness of doctors and their wives to prepare and to break the political ice in the year ahead may well decide the outcome of our crucial test in 1964.

Prescription for Public Relations

By R. W. Teed, M.D.

President, Washtenaw County Medical Society
Chairman, MSMS Public Relations Committee

With socialist politicians driving hard to move in to control hospital and medical care, we shall be forced to continue our opposition to measures which would impose this control.

In writing and speaking for the public on this matter, I think we should avoid reference to ourselves as the group principally involved. The term "socialized medicine" has become a bogeyman which scares nobody and probably should be dropped. The public will not "bleed" about what happens to the Medical Profession. Certainly the politicians will not be concerned about a group which totals about 250,000 people—about .1 per cent of the population.

Our approach, therefore, must be in the direction of what happens to the public, both economically and politically. If we can make people see their stake in this thing, perhaps they will take an interest. One must admit, however, that the promise of a present benefit, paid for by a future generation, is a political gimmick of the highest potency. Al Smith pointed out long ago that "nobody shoots Santa Claus," and this is just as true today as it was then.

In the meantime, we must maintain our good public relations by giving the public the finest medical care available at the lowest reasonable price. The cost of medical care is certainly not going to drop in the year ahead, but we should be sedulous in our attempt to eliminate any expense that does not result in diagnostic or therapeutic benefit to the patient.

Frogs and Freedom

By L. A. Drolett, M.D.
Lansing, Michigan

There's an old story that says that you can't kill a frog by dropping him in boiling water. He reacts so quickly to the sudden heat that he jumps out before he's hurt. But if you put him in cold water and then warm it up gradually, he never decides to jump till it's too late. By then he's cooked!

Men are just as foolish. Take away their freedom overnight, and you've got a violent revolution. But steal it from them gradually (under the guise of "security," "peace," or "progress") and you can paralyze an entire generation. Look at the income tax. It started out at a harmless sound 1%. It would have been easy to jump out of water as tepid as this, but like the frog, we waited while it climbed ever higher. (Try jumping now!)

Worst of all, we never learn. Even today we cannot believe that Medicare is the same warm water that will one day boil us in Socialized Medicine. We see no connection between farm price supports and Nationalized Agriculture. And if we draw a parallel between subsidized teachers' pay and federal control of education, we are called "extremist."

The tragedies of history are always repeated by those who refuse to learn them. To seek guidance from the past is not "turning the clock back" as we are so often told. It is merely a good way to keep out of hot water.

Editorial Comment

Something To Look Forward To

(*Wall Street Journal*, January 22, 1963)

Even those most sympathetic toward Social Security expansion must feel a twinge of uneasiness at the long series of tax boosts, the latest of which began shrinking paychecks on January 1.

And no one knows how much steeper the boosts would be if medicare plugged again by President Kennedy in his annual budget message becomes a reality. But for an idea of how far a nation can go with this business of legislating security for all, we can look at an older hand at the game.

In Italy, where a social security system began around the turn of the century, workers pay a tax equal to 8 per cent of their earnings, and employers are charged a levy equal to a huge 46 per cent of their total payrolls. In comparison the current 3⅝ per cent rate for both U. S. workers and their employers seems pretty piddling. Especially since the U. S. levy stops when wages hit $4,800 while the Italian tax goes right up to the top.

Italian workers get broader benefits, though they can hardly be called free. In addition to retirement pensions they receive full costs of doctors and medicines, liberal hospital benefits, maternity allowances, sickness benefits, special payments to supplement the income of workers with big families.

Still, things somehow aren't working too well. The system runs in the red, despite the high taxes. Despite the big benefits, workers complain of trouble getting medical care since doctors and hospitals have more patients than they can handle. And the whole system has grown so confusing that the Government subsidizes special "institutes" to try to help workers find their way through the maze.

So you see, there's still plenty of room for expanding our own Social Security bureaucracy and taxation. It gives us all something besides retirement to look forward to.

Doctors Should Protect Their Reputation

Los Angeles Times

The *Times* has supported the American Medical Association on principle in its fight against Medicare and some other vote-buying approaches to socialized medicine.

But on principle the AMA must be taken to task for failure to adopt the report of its judicial council, which declares it unethical for doctors to own a stock interest in pharmacies in the area of their practice.

This is a questionable sideline for doctors, because it does lay the profession open to criticism. When it can be charged that some doctors profit from prescriptions they write, all practitioners suffer.

Those doctors who have invested in pharmacies damage the ethical and moral case against Medicare by skating on thin ethical ice themselves. This ethical stricture does not, of course, apply to physicians who support a pharmacy as a public service in areas where none exists.

There are battalions of proponents of Medicare and worse proposals for tax-subsidized medicine who have baselessly attacked the professional integrity of physicians to further the cause of handouts. The failure to declare ownership of pharmacies by physicians unethical, as recommended by their own responsible committee, furnishes legitimate ammunition to the doctor-baiters who are always seeking to smirch the motives of organized medicine.

It is to be hoped that the governing body of the AMA moves quickly to reconsider, and to approve the recommendations against pharmacy ownership by physicians.

Forward Step

Lansing State Journal, August 9, 1962

Authorization by the Lansing city council this week for purchase, installation and early use of fluoridation water treatment facilities is a commendable forward step for this community. Unfortunately there has been a great deal of misunderstanding in the past regarding this process and its importance to the over-all health of the community.

Fluoridation of public water supplies is no longer in the experimental stage. It has passed both laboratory tests and the more rigid trial of long-continued public use in many communities across the country. Its value in reducing the incidence of tooth decay and the manifold ills derived therefrom can no longer be denied. It bears the endorsement of the American Medical Association, the American Dental Association and the American Public Health Association, all conservative professional bodies not given to endorsing products or processes which have failed in the slightest respect to measure up to meticulous standards of proved safety and therapeutic value.

The results are a matter of irrefutable record. Tooth decay has been minimized, particularly in children, in all communities that have adopted the process on a long-term basis. Because it helps prevent decay, fluoride stimulates healthy, all-around body growth in boys and girls and gives them a better chance for sound teeth later as adults.

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One tablet at bedtime and one in the morning, supplemented, if necessary, by additional tablets of Pro-Banthīne P.A. or standard Pro-Banthīne to meet individual requirements.

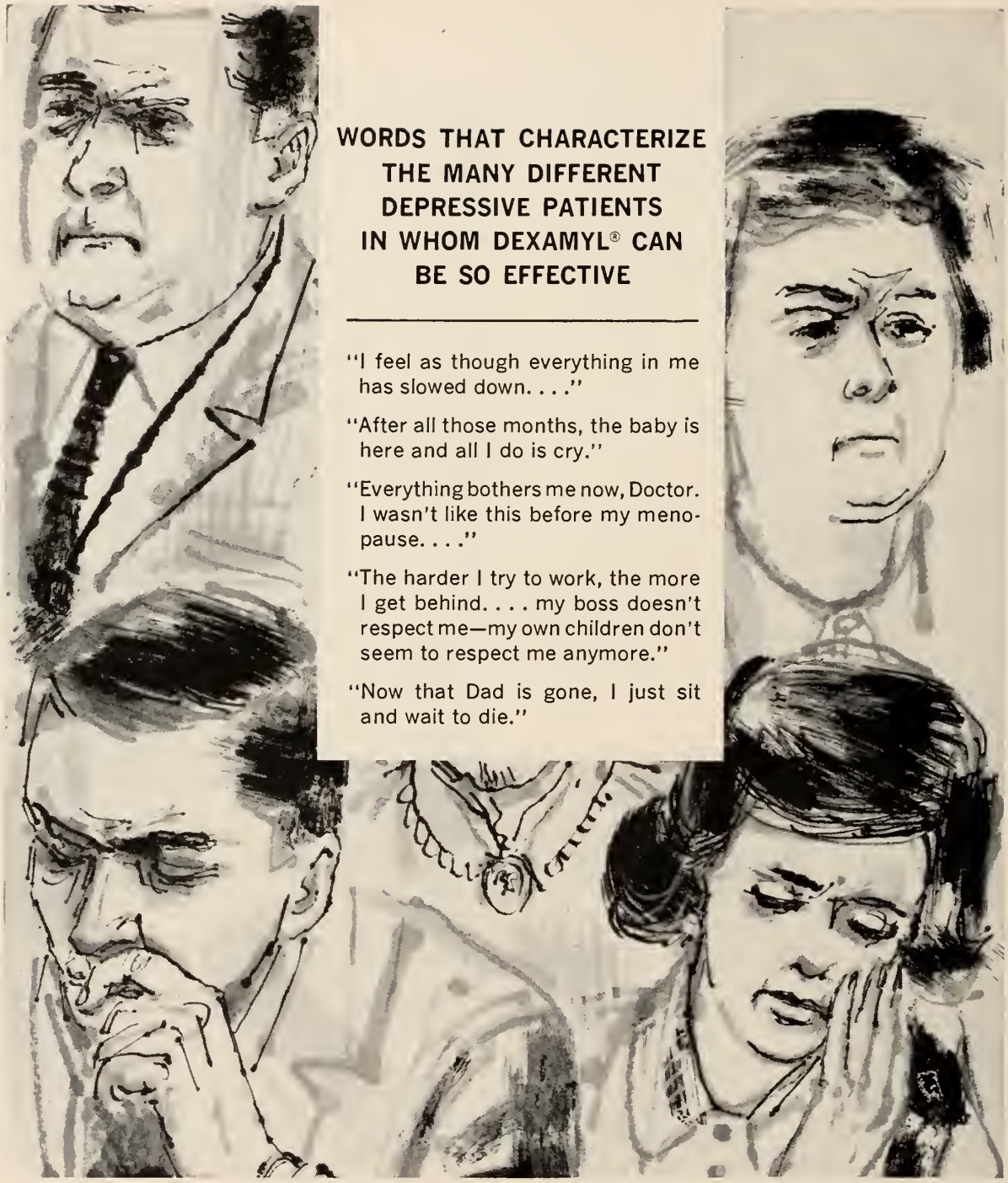
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Scott, Irvin Direct Health Council Work

Serving this year as president of the Michigan Health Council is Gordon H. Scott, Ph.D., Detroit, Vice President for Michigan College Development and Dean of the College of Medicine of Wayne State University. Doctor Scott, who is a Fellow of the American Association for the Advancement of Science and former Vice President of the Association of American Medical Colleges, came to Detroit and Wayne University in 1945.



G. H. Scott, M.D.



E. A. Irvin, M.D.

Earle A. Irvin, M.D., Grosse Pointe Park, Medical Director of the Ford Motor Company, is president-elect this year. Doctor Irvin has held offices in many state and national organizations and served as President of the American Industrial Medical Association in 1952-53 and as President of the Michigan Heart Association in 1956.

Both Doctor Scott and Doctor Irvin have served for several years on the Board of Trustees of the Michigan Health Council. In their new capacities they will take a major role in the development of the 1963 Michigan Health Council State Conference to be held at Grand Rapids during Michigan Week, May 21 through 23.

Kresge Hearing Research Center Dedication Soon

A new medical facility devoted exclusively to hearing and deafness research—the Kresge Hearing Research Institute—will be formally dedicated May 20 at the University of Michigan Medical School.

Dedication ceremonies will follow a tour of the five-story, $1,750,000 building by members of the Visiting Scientific Committee and will precede a public open house.

The Institute, made possible by the Kresge Foundation, will accommodate 48 staff members including investigators, assistants and supporting help.



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U-M Medical Graduates To Hear Doctor Hussey, AMA

Hugh H. Hussey, M.D., director of the American Medical Association's Division of Scientific Activities and former dean of Georgetown University School of Medicine, will be the principal speaker at the University of Michigan Medical School's Class Day exercises in the Rackham Amphitheater, June 7.

Dean William N. Hubbard, Jr., M.D., reports the medical school's 169-member senior class will take the Hippocratic Oath prior to receiving their Doctor of Medicine degrees the following day at the University's 119th commencement. Honors for outstanding achievement also will be presented.

49 Courses Conducted in State By Wayne Medical School

The Continuing Medical Education Program of the Wayne State University College of Medicine offers 49 courses in 11 areas during this spring quarter. Most courses will be offered at the College of Medicine or at Detroit Receiving Hospital. Others have been scheduled for Harper Hospital, Grace Hospital or at the Wayne County Medical Society.

Areas of study include anesthesiology, industrial medicine and hygiene, medicine, neurology, neurosurgery, physiological chemistry, physiology and pharmacology, psychiatry, radiology and surgery.

Offer Wet Clinics

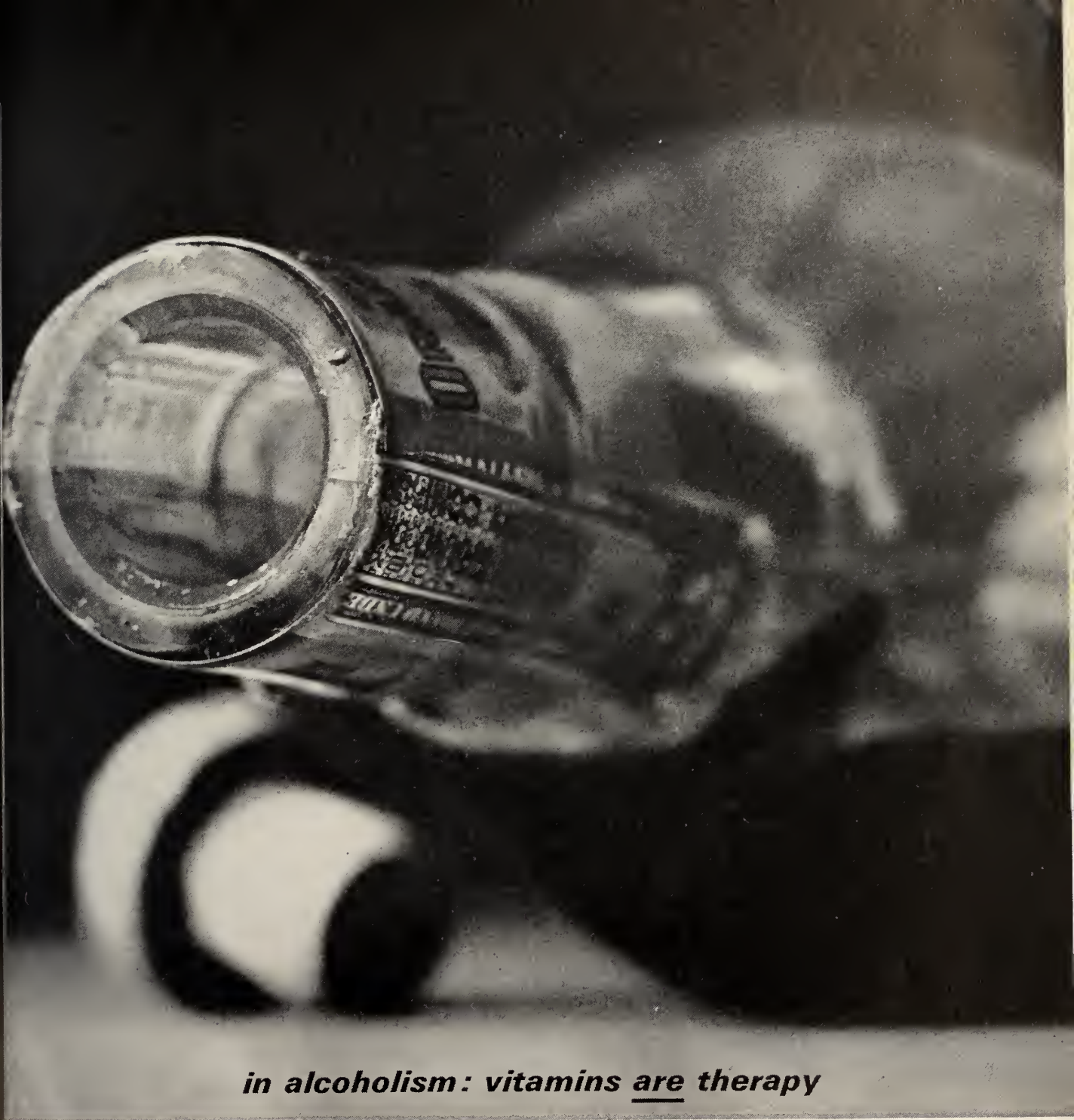
Wet clinics in cardiology are being offered by the Michigan Heart Association which will supply a lecturer, either surgical or medical. It is suggested that at least three to six local physicians with at least six patients with a wide variety of problems should participate. Histories and records of previous management, as well as x-rays, EKG's and laboratory studies also should be available.

If interested, write Michigan Heart Association, 13100 Puritan, Detroit 27.

Plans Moving Ahead for New Detroit Children's Hospital

Detroit's Children's Hospital, one of the oldest in the nation devoted entirely to infants and children, is the first "new" hospital scheduled to rise in the Detroit Medical Center. The hospital now is seeking 4 million dollars through public subscription toward the estimated 8-million-dollar building program. The rest will

(Continued on Page 522)



in alcoholism: vitamins are therapy

A full "comeback" for the alcoholic is partly dependent on nutritional balance... aided by therapeutic allowances of B and C vitamins. Typically, the alcoholic patient is seriously undernourished... from long-standing dietary inadequacy, from depletion of basic reserves of water-soluble vitamins.

Each capsule contains: Vitamin B_1 (Thiamine Mononitrate)...10 mg. / Vitamin B_2 (Riboflavin)...10 mg. / Niacinamide... 100 mg. / Vitamin C (Ascorbic Acid)...300 mg. / Vitamin B_6 (Pyridoxine HCl)...2 mg. / Vitamin B_{12} Crystalline... 4 mcgm. / Calcium Pantothenate...20 mg. Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100.

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Plans Moving Ahead for New Detroit Children's Hospital

(Continued from Page 520)

come through $1,840,000 allocated by the Metropolitan Detroit Building Fund, through an anticipated million dollars in federal grants, through a $250,000 bequest by the late Mrs. Sam Osnos, and through sale of its present property.

The new hospital—a six-story building with special services and departments and accommodations for 320 patients—is scheduled to rise in the heart of the new Medical Center near the proposed new Wayne State College of Medicine.

Hospital Week Focuses On Many Health Careers

Hospital careers are being emphasized this month during National Hospital Week, May 12-18, in hospitals across the country. The theme is "Today's Hospital—Career Center for America's Youth."

"The hospital is, indeed, a career center," Edwin L. Crosby, M.D., A.H.A., said. "It requires a variety of skills, professions, trades and talents. There is literally a hospital job for everyone."

The nation's 7,000 hospitals employ almost 1.7 million persons in some 200 job classifications. The hospital field ranks seventh in the number of persons employed. One of every 30 persons employed in the country works in a hospital.

Salute Future Nurses

The first national Future Nurses Clubs Day will be observed May 17 to honor 4,000 high school clubs exploring nursing and other careers. The American Medical Association, American Nurses' Association, National League for Nursing and the American Hospital Association sponsor this Committee on Careers project.

Annual spot checks indicate that the proportion of FNC members graduating from high school and entering nursing or other health careers has risen from 53 per cent to 61 per cent in the past five years.

A 50 per cent risk of developing coronary heart disease before age 65 is associated with combinations of any two or all of three factors—overweight, high blood pressure, and excessive serum cholesterol, according to *Patterns of Disease*, a Parke, Davis & Company publication for physicians.

1962 Hospital Construction Expenditures Climb Again

Expenditures for hospital construction boomed in 1962 when an average of $3.6 million a day was spent building hospitals, nursing homes and other health-related institutions.

A total of $1,322,000,000 was spent on such construction in 1962, marking the seventh straight year of increasing expenditures for these purposes.

Last year's expenditure was a 14.3 per cent increase over the $1,157,000,000 spent on hospital construction in 1961. These high-expenditure levels are expected to continue.

During 1962, seven of every ten dollars spent on hospital construction came from private capital which put up $925 million of the $1,322,000,000 total. Public funds accounted for $397 million, or 30 per cent.

Kiwanis International Wants Minimum of Government Services

"Government should hold its activities and services to a minimum level necessary to protect its citizens."

That statement was adopted by the Kiwanis International Board of Directors, which also declared that "Kiwanians view with deep concern any excessive and costly expansion of government by enlarging the number, functions and powers of government bureaus and agencies."

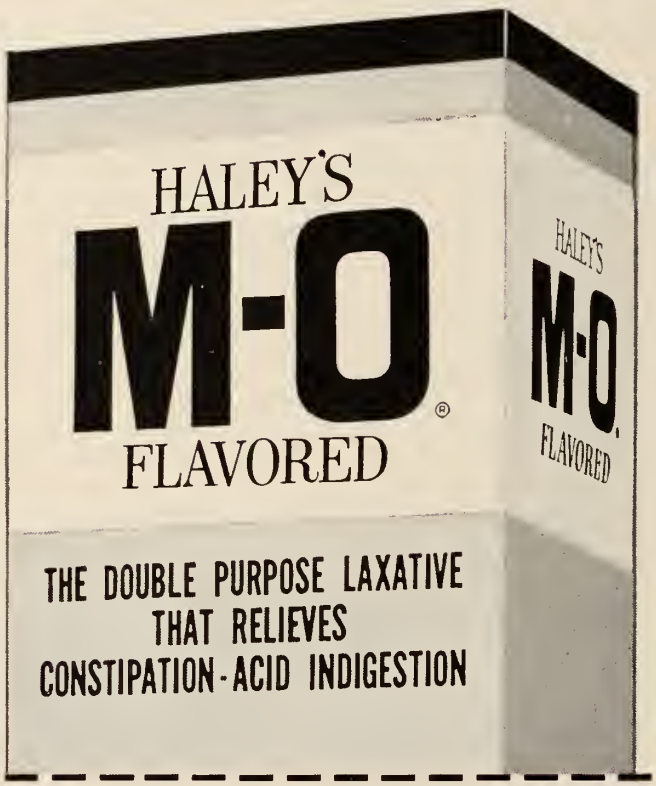
The statement also lauded efforts of individuals through cooperative action "to provide effective solutions to the many and varied needs of youth and adults alike who desire to live in a successful free enterprise system."

Falls Hurt 12 Million Annually

Injuries sideline an average of 45 million Americans each year, with nearly half the injuries being sustained in accidents in the home. The National Center for Health Statistics said falls top the list of injury causes, with about 12 million persons annually suffering injuries in such accidents.



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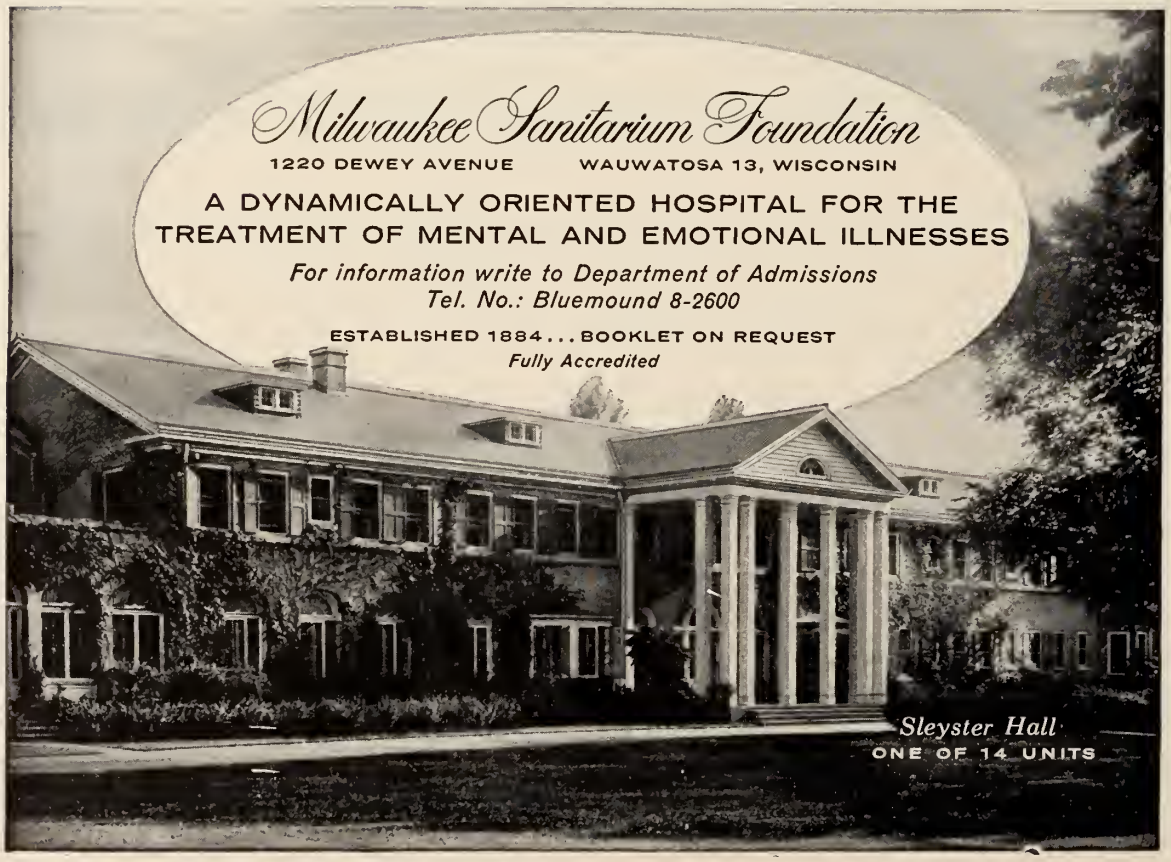
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On Signing of Death Certificate

Dear Doctor,

I have your inquiry relative to the role of the doctor in "pronouncing a patient dead". I assume that your inquiry pertains to that class of cases in which the deceased has been a patient in the hospital and dies from natural causes rather than that class of cases in which death results from unnatural causes or under suspicious circumstances which require reporting to the coroner.

The laws of the State of Michigan do not require a specific pronouncement or declaration that a person is dead other than through the signing of a death certificate. You are, of course, familiar with the statutory requirement that the attending physician sign the death certificate. In my opinion this does not mean that the physician must actually be present at the time of the person's death or that he must make any formal pronouncement of death over the body of the deceased.

No physician can properly sign a death certificate without satisfying himself that the person referred to is actually dead, but I believe that if a physician who ascertains the fact of death through a registered nurse or other person competent to determine the fact, may properly sign the death certificate without having made any formal pronouncement of death over the body.

LESTER P. DODD, D.J.
Legal Counsel



LEGAL OPINION 527

About Hospital Immunity

The following item is quoted directly from Vol. 6, No. 11 of *The Citation*, a newsletter prepared by the Law Department of the American Medical Association:

Charitable Hospital Doesn't Lose Immunity by Carrying Insurance—A charitable hospital immune from liability did not lose its immunity by purchasing and maintaining liability insurance. The Michigan Supreme Court so ruled in approving the denial of a motion for discovery of a hospital's liability insurance policy. Dismissal of the suit against the hospital was affirmed.

The patient alleged that he suffered permanent injuries in May, 1955, as a result of negligent acts of hospital personnel. Suit was dismissed because of the immunity of the hospital. The appellate court held that discovery was properly denied and that the patient was not entitled to a jury trial on the charitable status of the hospital. *Podvin v. St. Joseph Hospital*, 119 N.W. 2d 108 (Mich., Jan. 11, 1963)

EDITOR'S NOTE: The doctrine of charitable immunity was overturned by the Michigan Supreme Court in Parker v. Port Huron Hospital, 105 N.W. 2d 1, with respect to any claim arising *after* September 15, 1960. See *The AMA Citation*, Vol. 3, No. 5, p. 22.

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Brief and to the Point

ELECTED—Kenneth P. Mathews, M.D., Ann Arbor, was named president-elect of the American Academy of Allergists at the organization's recent annual meeting. He will take office in 1964.

TAKES HOSPITAL POST—Scott T. Harris, M.D., Ypsilanti, has assumed new duties as chief of medical services at the Plymouth State Home and Training School. He had practiced in Ypsilanti for 16 years, specializing in pediatrics.

DIPLOMATES—Seven pathologists have been named Diplomates of the American Board of Pathology. Those named were David C. Angell, M.D., Ann Arbor; Gene T. Fries, M.D., Ann Arbor; Joseph C. Hathaway, Jr., M.D., Detroit; Denis A. Luz, M.D., Detroit; Robert A. Peterson, M.D., Detroit; Joseph C. Schaefer, M.D., Petoskey; and Frank B. Walker, M.D., Detroit.

SELECTED—Keats K. Vining, Jr., M.D., Grand Rapids, and Herschel A. Shulman, M.D., Detroit, were elected chairman and vice-chairman, respectively, of the Clinical Society of the Michigan Diabetes Association at the Society's annual meeting held during MCI. The Society heard Robert Bradley, M.D., Boston, speak on "A Second Look at Hypophysectomy in Diabetes Retinopathy."

JOINS SURVEY—Leo J. Miedler, M.D., Ann Arbor, is a member of a U. S. medical team which will conduct a nutrition survey in northeastern Brazil from March 1 to May 15. He was named a special consultant to the U. S. Department of Health, Education and Welfare for the trip.

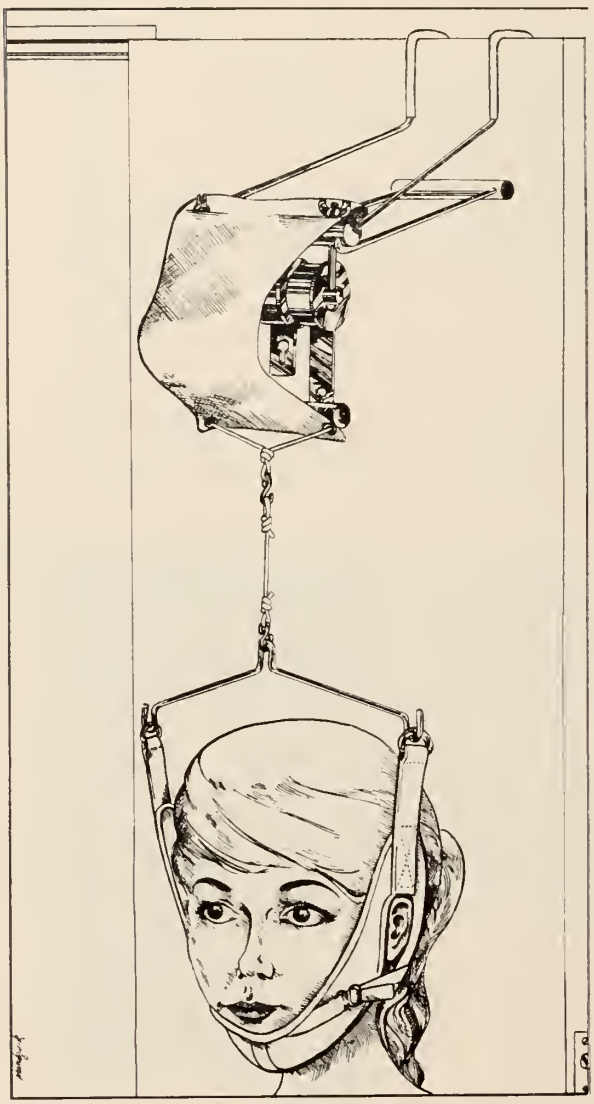
HONORED—Gerald D. Abrams, M.D., Ann Arbor, has been selected a Markle Scholar in Academic Medicine and will receive a $30,000 stipend over a five-year period. When he was graduated from the University of Michigan Medical School in 1955, he received the Oreon Scott Award for outstanding academic achievement and the Borden Undergraduate Medical Research Award as the student having the greatest distinction in research that year.

ON PROGRAM—Max K. Newman, M.D., Detroit, appeared on the recent program of the Michigan Welfare League's Legislative Forum at the Michigan State University. He was chairman of the Health Workshop. Appearing at this same meeting was Albert E. Heustis, M.D., Commissioner of the Michigan Department of Health, and Donald C. Smith, M.D., acting director of the Michigan Crippled Children's Commission.



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INSTALLED— E. C. Swanson, M.D., Vassar, was recently installed as president of the Federation of State Medical Boards of the United States at the Annual Congress on Medical Education and Licensure held at the Palmer House in Chicago. Doctor Swanson has for the past 12 years been active as a member and Secretary of the Michigan Board and an officer of the Federation. The Congress is sponsored by the Council on Medical Education and Hospitals of the AMA and the Federation of State Medical Boards of the United States.

* * *

ELECTED— Ralph S. Green, M.D., medical director of the Haven Sanitarium, Rochester, was elected president of the Central Neuropsychiatric Hospital Association at its recent annual meeting in Chicago.

* * *

CITED— Thomas M. Batchelor, M.D., Detroit, received recently the NAACP Achievement Award in Detroit for "The most outstanding contribution by a Negro citizen in his particular field of endeavor." An internist, Dr. Batchelor serves as health commissioner for the Detroit Board of Health and as a member of the State Board of Registration in Medicine.

* * *

HONORED— Three Grand Rapids doctors recently were honored by their Selective Service Boards for 20 years of service as medical advisors. Those cited were Edson H. Fuller, Jr., M.D.; R. Earle Smith, M.D., and Aaron V. Wenger, M.D.

* * *

BUSY DOCTOR— Robert E. Rice, M.D., Greenville, is not only busy in medical organizations but is serving now as District Governor of Lions International. He is a past president of the Greenville Lions Club and a former zone chairman. In medical circles, Doctor Rice serves now as a delegate from Ionia-Montcalm County Medical Society to the MSMS House of Delegates and as an alternate delegate from Michigan to the AMA.

* * *

OFFER BOOKLETS—Two new booklets—"Planning Fat Controlled Meals for 1200 and 1800 Calories" and "Planning Fat-Controlled Meals For Unrestricted Calories," are now available from the Michigan Heart Association, 13100 Puritan, Detroit 27. A single copy will be given free to a patient upon a prescription, or on request to a professional person. The booklets contain suggestions for shopping, cooking and eating out.

* * *

PUSHES HEALTH— The United States Junior Chamber of Commerce will make five grants of $100 each to Jaycee chapters showing the "greatest accomplishment in health programming" during 1963-64.

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ACOG FELLOWS— The American College of Obstetricians and Gynecologists reports the names of the following new Michigan Fellows, inducted into the College: Adrian—Francis A. Locke, M.D; Ann Arbor—David G. Anderson, M.D., Richard A. Kutcipal, M.D.; Birmingham—Kenneth I. Ranney, M.D.; Dearborn—Thomas DeLawrence, M.D.; Detroit—Alan C. Lakin, M.D., Kamran S. Moghissi, M.D., Donald C. Swan, M.D., Sidney F. Katz, M.D.; Grand Rapids—Harold E. Veldman, M.D., Harrison C. Visscher, M.D.; Lansing—Joseph A. Caruso, M.D., Richard S. Johnson, M.D., H. E. Malcolm; Midland—William E. Harrigan, M.D.; Warren—William A. Starbird, M.D.

* * *

FELLOWSHIPS—Medical schools are again being offered student research fellowships under a Tobacco Industry Research Committee. Clarence Cook Little, M.D., Scientific Director of T.I.R.C., reports the fellowships encourage medical students to undertake medical research projects whether or not they intend to seek a career in research.

* * *

ON PROGRAM—Three Michigan men filled roles of leadership at the recent annual meeting of the Piedmont Orthopedic Society (comprised of men who had their orthopedic training at Duke) at Sea Island, Georgia. Howard J. Schaubel, M.D., Grand Rapids, president of the Society this year, presided. William T. Davison, M.D., Port Huron, moderated the scientific session one day, and John S. Campbell, M.D., Bay City, was in charge of one of the discussion groups.

* * *

RECEIVES GRANT—The Wayne State University College of Medicine has received a grant of $163,722 from the National Institutes of Health to continue general research work.

* * *

VISIT U-M—Several hundred Michigan high school students and their counselors visited the University of Michigan Medical School April 6 for "Annual Students Day." They were greeted by Dean William N. Hubbard, Jr., M.D., and heard talks by Frank Whitehouse, Jr., M.D.; Earl F. Wolfman, Jr., M.D., and Fred J. Hodges, M.D., and others.

* * *

HIRSCHFELD APPOINTED TO COMMISSION—Governor Romney has appointed Alexander Hirschfeld, M.D., Detroit psychiatrist, to the State Commission for the Aging. Doctor Hirschfeld was recommended by the Michigan Health Council which appoints one member to the 12-member group. He fills the vacancy created by the death of Harry Zemmer, M.D., Lapeer.

Doctor Hirschfeld is an active member of the MSMS Geriatrics Committee and has participated in many MSMS seminars and projects concerning problems of the aged.

USA CALENDAR

American Medical Association Annual Session June 16-20, Atlantic City House of Delegates June 17, Treymore Hotel, Atlantic City.

American College of Chest Physicians, June 13-17, Atlantic City.

American Academy of Physical Medicine and Rehabilitation, Sheraton-Dallas Hotel, Dallas, August 26. President M. K. Newman, M.D., 16861 Wyoming Ave., Detroit 21.

American Hospital Association, Waldorf Hotel, New York City, August 26-29. Director Edwin L. Crosby, M.D., 840 N. Lake Shore Dr., Chicago 11.

American Association of Obstetricians and Gynecologists, Homestead, Hot Springs, Va., September 5-7. Secretary Clayton T. Beecham, M. D., 3911 Vaux St., Philadelphia 29.

American Urological Association (Northeastern Section), Chateau Frontenac, Quebec, September 22-25. Secretary-Treasurer David W. Kline, M.D., Medical Center Clinic, Greensville, Pa.

Congress on Occupational Health, Jack Tar Hotel, San Francisco, September 25-26. AMA Council on Occupational Health, 535 N. Dearborn, Chicago 10.

National Rural Health Conference, Arlington Hotel, Hot Springs, Ark., September 20-21. Arline Hibbard, 535 N. Dearborn, Chicago 10.

American Academy of Ophthalmology and Otolaryngology, New York Hilton Hotel, New York City, October 20-25. Secretary W. L. Benedict, M.D., 15 Second St., S.W., Rochester, Minn.

American Academy of Pediatrics, Palmer House, Chicago, October 5-10. Executive Director E. H. Christopherson, M.D., 1801 Hinman Ave., Evanston, Ill.

American Association for the Surgery of Trauma, Mark Hopkins Hotel, San Francisco, October 24-26. Secretary Sawnie R. Gaston, M.D., 180 Fort Washington Ave., New York 30.

American Heart Association, Oct. 25-29, Los Angeles.

American Academy of Ophthalmology and Otolaryngology Seminars, Oct. 26-Nov. 1, Hamilton, Bermuda.

American College of Gastroenterology, Shoreham Hotel, Washington, D. C., October 20-23. Executive Director Daniel Weiss, 33 W. 60th St., New York 23.

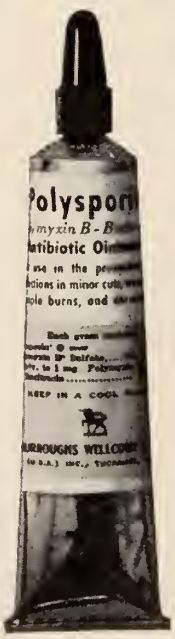
American College of Surgeons, San Francisco, October 28-November 1. Secretary Samuel P. Harbison, M.D., 40 E. Erie, Chicago 11.

American Medical Writers' Association, Pick-Congress Hotel, Chicago, October 10-13. Executive Secretary James E. Bryan, 250 W. 57th St., New York 19.

American Roentgen Ray Society, Queen Elizabeth Hotel, Montreal, October 8-11. Secretary C. Allen Good, M.D., Mayo Clinic, Rochester, Minn.

Association of American Medical Colleges, Sheraton-Chicago Hotel, Chicago, October 23-November 1. Secretary Richard H. Young, M.D., 303 E. Chicago, Chicago 11.

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Congress of Neurological Surgeons, Denver-Hilton, Denver, October 8-12. Secretary John R. Russell, M.D., 1815 W. Capitol Ave., Indianapolis 2.

Indiana State Medical Association, Murat Temple, Indianapolis, October 16-18. Executive Secretary J. Waggener, 3935 N. Meridan, Indianapolis.

International Congress of Plastic Surgery (3rd). Sheraton-Park Hotel, Washington, D.C., October 13-18. Secretary-Treasurer L. H. Backus, M.D., 217 Linwood Ave., Buffalo 9.

American Association of Blood Banks, Statler Hilton Hotel, Detroit, November 5-8. Secretary E. Arthur Dreskin, M.D., 11 Summer St., Greenville, S. C.

American College of Physicians (sectional meeting), Detroit, November 21-23. Executive Director Edward C. Rosenow, Jr., M.D., 4200 Pine St. Philadelphia 4.

Gerontological Society, Sheraton Plaza Hotel, Boston, November 7-10. Secretary Robert W. Kleemeier, Ph.D., Washington University. Skinker and Lindell Blvds., St. Louis 30.

American Medical Association (Clinical Meeting), Memorial Coliseum, Portland, Oregon, December 1-4. Executive Vice-President F. J. L. Blasingame, M.D., 535 N. Dearborn, Chicago 10.

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IN MEMORIAM

A. ALAN AGREE, M.D., 59, retired Detroit physician, died March 7, 1963.

A 1928 graduate of Wayne State University College of Medicine, Doctor Agree had practiced in the Detroit area for 30 years. He retired three years ago. He was an Associate member of the Michigan State Medical Society.

WILBUR W. FOSGET, M.D., 63, Lansing physician since 1928, died March 25, 1963.

A 1925 graduate of the University of Michigan Medical School, Doctor Fosget served his internship at U-M Hospital and his residency at Sparrow Hospital, Lansing. Doctor Fosget was senior staff member at Sparrow, St. Lawrence, and Ingham Medical Hospitals, secretary and treasurer of the Edward W. Sparrow Hospital executive staff and general medical staff from 1942 to 1946. He was a member of the American Academy of General Practice.

LOUIS E. KAMIN, M.D., 64, Detroit physician for 33 years, died March 23, 1963.

Doctor Kamin had been an internist at the Web Clinic, Detroit, for 18 years. A native of Russia, Doctor Kamin was educated at the University of Pennsylvania, the University of Michigan and Wayne State University. He was on the staff of Detroit Memorial Hospital and was a member of the Maimonides Medical Society. He was an Associate member of the Michigan State Medical Society.

BRYCE A. MILLER, M.D., 77, Flushing physician since 1935, died March 4, 1963.

A 1914 graduate of the University of Michigan Medical School, Doctor Miller served as an Army surgeon in World War I. Following this, he practiced in Ohio, Monroe and Texas before coming to Flushing. He was village president of Flushing from 1942 to 1946, and was a member of Nu Sigma Nu Medical Fraternity.

Doctor Miller was a retired member of the Michigan State Medical Society.

JOHN B. MORTON, M.D., 89, Oak Park, died February 27, 1963.

A graduate of Bellevue Hospital Medical College, New York, in 1897, Doctor Morton practiced 20 years in Illinois, before returning to Bellevue to do postgraduate work in eye, ear, nose and throat diseases.

Doctor Morton moved to Detroit in 1923 and was associated with the Warren Avenue Diagnostic Hospital. He was also on the staffs of Children's and Women's Hospitals. He retired in 1962.

He was a life fellow of the Academy of Ophthalmology and Laryngology, an honorary member of the Detroit Otological Society, a member of the American College of Surgeons, and a Life Member of the Michigan State Medical Society.

Michigan Authors

Leo S. Figiel, M.D. and **Steven J. Figiel, M.D.,** Detroit, "Barium Examination of Cecum in Appendicitis", *Acta Radiologica,* November 1962.

Tommy N. Evans, M.D., Ann Arbor, "Teratogenic Agents", *Industrial Medicine and Surgery,* March, 1963.

Carey P. McCord, M.D., Ann Arbor, "Cork Legs and Iron Hands", *Industrial Medicine and Surgery,* March, 1963.

J. W. Conn, M.D. Ann Arbor, "Aldosteronism in Man", *Journal American Medical Association,* March 9, 1963.

Richard E. Straith, M.D., Detroit, "The Speed Tie", *The Journal of the International College of Surgeons,* March, 1963.

R. D. Stewart, M.D., E. A. Boettner, M.Sc., R. R. Southworth, M.D. and **J. C. Cerny, M.D.,** Ann Arbor, "Acute Carbon Tetrachloride Intoxication", *Journal, American Medical Association,* March 23, 1963.

Blood Banks Serve Many

The American Association of Blood Banks, founded in Dallas in 1947, now has 3,800 institutional and individual members in all states and many countries. The newest institutional member is the Blood Bank of Alaska, Inc., at Anchorage.

The Association has established standards for blood banks, has a national blood clearinghouse system, regional reference laboratories and maintains a central file for rare donors. Since May 27, 1961, clearinghouses of the Association and Red Cross have cooperated to permit local donations of blood for credit anywhere in the country.

The blood bank movement includes many interesting incidents:

Bernard Fantus, M.D., established the world's first blood bank at Cook County Hospital in Chicago in 1937. New York municipal hospitals started banks the next year. The San Francisco Medical Society founded a community bank in 1941. The Massachusetts General Hospital established a bank in 1942 in time to save many of the hurt in the Coconut Grove fire. New York mustered 1,500 donors on a cold November night in 1950 to aid the injured in a Long Island Railroad wreck.

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The Doctor's Library

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

CANCER. Diagnosis, Treatment, and Prognosis. Third Edition. By Lauren V. Ackerman, M.D., Professor of Surgical Pathology and Pathology, Washington University School of Medicine, St. Louis, Mo.; Surgical Pathologist, Barnes Hospital and Affiliated Hospitals, St. Louis, Mo.; Consultant to the Ellis Fischel State Cancer Hospital, Columbia, Mo.; Consultant to the Armed Forces Institute of Pathology; Member, Subcommittee on Oncology, National Academy of Sciences—National Research Council, and Juan A. del Regato, M.D., Director, Penrose Cancer Hospital, Colorado Springs, Colo.; Associate Professor of Radiology, University of Colorado Medical School, Denver, Colo.; Member, Clinical Studies Panel, National Cancer Chemotherapeutic Center; Member, Advisory Commission on Biology and Medicine, University of Puerto Rico Nuclear Center; Consultant, Lackland Air Force Base Medical Center; Consultant, Veterans Administration Hospitals. With 799 text illustrations and 4 color reproductions. Saint Louis: C. V. Mosby Company, 1962. Price, $29.50.

This is the third edition of a text on cancer, that has been well accepted. Extensive revision of all chapters together with numerous new references have been added. New trends in radiotherapy and surgery of cancer, as well as hormone and chemotherapy are included, but detailed discussions of the latter are purposely omitted. As in previous editions, the principal aim continues to be a natural history of the disease, diagnostic means, and therapeutic possibilities with particular regard to prognosis.

The first 160 pages deal with general considerations, and the remaining portion of the book discusses specific cancer according to systems, as in previous editions. The text is well illustrated, although only four color plates are included. A good bibliography follows each section.

Discussion is concise, beginning with anatomy, followed by a discussion of incidents, etiology, pathology, diagnosis, and finally, treatment and prognosis. Diagrams of lymphatic extension are particularly lucid.

The text is of value for all classes of medical reader from medical student to experienced physicians, but is in no sense an encyclopedic compilation of knowledge of the subject.

Although weak on treatment, particularly chemotherapy, the text is useful to the physician in practice.

R.W.B.

ADVANCES IN RHEUMATIC FEVER, 1940-1961. By May G. Wilson, M.D., Professor of Clinical Pediatrics, Emeritus, Cornell University Medical College; Consulting Pediatrician and Director, Rheumatic Fever Research, The New York Hospital, New York City. A Commonwealth Fund Book. New York: Hoeber Medical Division, Harper & Row, 1962. Price, $10.00.

This is a Commonwealth Fund-sponsored monograph, which is intended as a supplement to the former monograph on

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the same subject, covering the period of 1940-1961. Detailed coverage of long term observations, the natural history of the disease, and the results of such investigations are presented. Epidemiological studies are presented together with the discussion of the current concepts of the nature of the disease and the biochemical and immunologic factors in its pathogenesis. Particular attention is paid to the heart and to the diagnostic criteria for rheumatic heart disease, its course and its management. Prevention, as well as therapy, receives careful consideration. Only brief attention to surgical correction of valvular deformities and its indications is given. An extensive bibliography follows each section. This book should be useful to those interested in the field.

R.W.B.

BOOKS RECEIVED

BRAY'S CLINICAL LABORATORY METHODS. Sixth edition. Revised by John D. Bauer, M.D., Director of Laboratories, DePaul Hospital, St. Louis, Mo.; Director of Laboratories, Faith Hospital, St. Louis, Mo.; Consultant Pathologist, Lutheran Hospital, St. Louis, Mo.; Assistant Professor, Washington University School of Medicine (Pathology), St. Louis, Mo.; Gelson Toro, Ph.D., Assistant Director of Scientific Research, Gerontological Research Foundation, St. Louis, Mo.; Consultant in Biochemistry and Clinical Chemistry, St. Louis Chronic Hospital and Missouri Clinical and Biochemical Laboratory, St. Louis, Mo., and Philip G. Ackermann, Ph.D., Research Assistant Professor, Division of Gerontology, Washington University School of Medicine, St. Louis, Mo.; Biochemist, St. Louis Chronic Hospital, St. Louis, Mo. 142 illustrations and 16 color plates. St. Louis: The C. V. Mosby Company, 1962. Price, $10.50.

LABORATORY MEDICINE—HEMATOLOGY. By John B. Miale, M.D., Professor of Pathology, University of Miami School of Medicine, Coral Gables, Florida, and Director of Clinical Pathology, Jackson Memorial Hospital, Miami, Florida. Second edition. 320 illustrations and 26 plates, including 10 in color. St. Louis: C. V. Mosby Company, 1962. Price, $17.00.

SYNOPSIS OF NEUROLOGY. By Francis M. Forster, B.S., M.D. Professor and Chairman, Department of Neurology, University of Wisconsin School of Medicine, Madison, Wisconsin. St. Louis: The C. V. Mosby Company, 1962. Price, $6.75.

SYNOPSIS OF GENITOURINARY DISEASE. By Austin I. Dodson, Jr., M.D., Associate Clinical Professor of Urology Medical College of Virginia, Richmond, Va., and J. Edward Hill, M.D., Assistant Clinical Professor of Urology, Medical College of Virginia, Richmond, Va. Seventh edition. 123 illustrations. St. Louis: The C. V. Mosby Company, 1962. Price, $7.75.

VISUAL PROBLEMS IN AVIATION MEDICINE. Edited by Dr. Armand Mercier, France. Published for and in behalf of Advisory Group for Aeronautical Research and Development, North Atlantic Treaty Organization. A Pergamon Press book. New York: Macmillan Company, 1962. Price, $6.00.

Letters to the Editor

Dear Doctor Haughey:

I want to express my grateful thanks to the Michigan State Medical Society for having your President, Doctor Clarence I. Owen, attend the Annual Congress in Medical Education and Licensure when I was elected President of the Medical Board of Examiners of the United States.

The Michigan State Board of Registration in Medicine will look for cooperation and active support from the Michigan State Medical Society so that we may steer with safety, the programs of Medicine, in which we are all interested, amidst the conflicting elements of a troubled world.

Sincerely yours,

E. C. Swanson, M.D.
Executive Secretary,
Michigan State Board of Registration in Medicine

Lansing, Michigan
March 15, 1963

*

Dear Doctor Haughey:

I have just received the February issue of The Journal of the Michigan State Medical Society and I am pleased and flattered and made happy that you were good enough to allow some of my friends to say so many nice things about me. So I hasten to send thanks to you and to your staff.

May I also say that I have always been very proud of The Journal and think that it has never been stronger scientifically and more interesting than it is at the present time under your leadership. I congratulate you.

With every kind personal wish, I am,

Sincerely yours,
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President's Page

DO YOUR DUTY



Clarence D. Owen
President
Michigan State Medical Society

Wagner-Murray-Dingell . . . Forand . . . King-Anderson.

Each attempt to socialize medicine has been met and turned back by an aroused profession acting in concert with its many friends.

Each time the margin of victory has been narrower. Today the new King-Anderson probably can pass the Senate. Only a few votes in the House hold the line. Hearings begin this summer, and we can expect the pressure for passage to mount from that point on until a decisive vote is taken.

That, in short, is the past and the present. Can we win? What will the future be?

Our leaders on the national level think we can win but they say it must be done by the individual efforts of the individual doctor and his friends. They have developed an action program to marshall these individual forces so they will have most telling effect and greatest chance for success. It's called OPERATION HOMETOWN. The story of OPERATION HOMETOWN is detailed on page 550.

Read about it.

See that your County Society is doing something about it. Do your duty. Do it now.

1963 Annual Session Plans Moving Ahead



Plans for the 1963 Annual Session at Grand Rapids, September 22-27, are well underway.

Busy with the early preparations is the MSMS Annual Session Committee on Arrangements and Program. The chairman is H. A. Towsley, M.D., of Ann Arbor.

MSMS members may be interested in the general patterns used by the Committee in selecting speakers and topics. Here are some of the guidelines:

In allocating speakers, every attempt is made to have outstanding speakers as lead-off men at the beginning of the show, at the end of the show, and also at the beginning of every morning's program.

Guest Essayists on the Assembly program are assigned to appropriate periods so they can be used also on the section meeting program if so desired.

If at all possible, guest speakers are not placed on the Assembly program one period immediately preceding the section meeting if the same speaker is to be used on the section meeting program, to obviate delays in the program.

Most Assembly speakers are from out-of-Michigan while Michigan M.D.'s are used as moderators of symposia or panels.

All speakers (whether Assembly or section) must be members of their state medical societies, AMA, or the Canadian Medical Association.

Section programs may be scheduled at luncheon, or immediately after adjournment of the afternoon Assembly, or may take the form of an evening meeting with dinner—at the discretion of the section officers in each instance.

Section meetings, if at all possible, are not held Thursday evening during the hours of the State Society Dinner Dance (7:00 p.m. to 11:00 p.m.), in order that all members and their ladies have the opportunity to attend this top social event of the MSMS Annual Session.

June Designated "Immunization Month"

To encourage immunization, the Michigan State Medical Society Council on May 15, designated June as "Immunization Month."

As of May 15, there were 28 component societies which also had voted to conduct a special educational effort. MSMS is making small, attractive placards available for doctor's waiting rooms. The placards read "This is Immunization Month—Ask the doctor about protection against Smallpox, Tetanus, Polio, Whooping Cough, Diphtheria."

"Operation Hometown" Project Under Way

"Operation Hometown" is the American Medical Association's program to offset the mounting pressure for King-Anderson legislation in the 88th Congress. Planned specifically for county medical societies and their members, the campaign is a continuing nationwide effort.

The program is outlined in seven "how-to-do-it" sections. They are:

County Campaign Chairman Coordination.—Includes sample speeches, activity cards, organizational and follow-up tips to help chairmen enlist interest and active participation of physicians.

County Speakers Bureau.—Tells chairmen how to book medicine's spokesmen before service clubs, civic groups, fraternal organizations, women's clubs and other appropriate audiences. Also contains a variety of speeches, literature distribution plans, news releases, report forms and background information for fielding questions from the floor.

Enlisting Allies.—Features aids for contact, program presentations and coordinating plans. Multiplicity of effort is stressed.

Newspapers, Radio and TV.—Supplies publicity suggestions, press statements, TV and radio scripts, lists of tapes and films, advertisements, and tips on how to contact editors and station managers.

Materials Distribution.—Provides up-to-date information for distribution in physicians' offices, pharmacies, hospitals and public areas.

Congressional Contact.—Has as its main objectives providing accurate information to all Congressmen on the issue and decreasing the efforts of the opposition.

Letter Writing.—Encompasses the two-fold activity of promoting correspondence to newspapers and with Congressmen. This section includes the "do's and don'ts" of letter writing, when and how often, and who and to whom.

"Operation Hometown," says the American Medical Association, "can't be accomplished in Chicago or in Washington offices, but only by you and your county medical society. It takes time, effort, planning and coordination. In short, 'grass roots' are reached only by digging, and dig we must if we are to preserve the high quality of medical care now available to all our patients."

Michigan Doctors Invited To Coller-Penberthy Event

Northern Michigan's outstanding medical event, the annual Coller-Penberthy Medical Conference, will be held in Traverse City, July 25 and 26. All meetings will be held at the Park Place Hotel.

Two changes are being introduced this year. The evening banquet will include an invitation to the ladies, and the program will be of special interest to them as well as to the visiting physicians. In addition, a golf tournament, under the sponsorship of the Medical Conference, is being planned for Friday afternoon.

Among the speakers who have already agreed to participate are Doctors Carl E. Badgley, Reed M. Nesbit, A. James French, Harry A. Towsley, Arthur C. Curtis, Isadore Lampe, Norman F. Miller, Edgar A. Kahn, all of Ann Arbor; and Doctors G. Thomas McKean, Clifford D. Benson, Richard J. Bing and Alan Thal, all of Detroit. In addition, coming from out-of-state will be Doctors Mark A. Hayes, of New Haven, Connecticut; Edwin H. Ellison, of Milwaukee; William A. Altemeier, of Cincinnati; Merle M. Musselman, of Omaha; and Lester R. Dragstedt, of Gainesville, Florida.

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George Kadian, M.D.
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Clarence Kooiker, M.D.
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18471 Haggerty Rd.
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19953 Weyher
Livonia, Michigan
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For the Patient Over 50 with Digestive Distress

KANUMODIC®

Each tablet contains methscopolamine nitrate, 2 mg.; and pentobarbital (Warning: May be habit-forming), 8 mg.; plus KANULASE® (cellulase standardized to 9 mg.; combined with pepsin, N.F., 150 mg.; glutamic acid hydrochloride, 200 mg.; pancreatin, N.F., 500 mg.; ox bile extract, 100 mg.).

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Table I—Symptomatic Relief in 25 Patients
(totalling 100 symptoms)

	COMPLETE RELIEF	PARTIAL RELIEF	NO RELIEF	TOTAL SYMPTOMS
KANUMODIC	59	17	24	100
PLACEBO	1	33	61	95

In a second study, Kanumodic produced "highly gratifying symptomatic relief" in 46 of the 60 patients participating.

Tested in patients over 50*. . . The effectiveness of Kanumodic was matched against placebo response in a study involving twenty-five "over 50 patients" suffering from functional bowel distress. All patients complained of one or more symptoms. A follow-up study of 60 additional cases (average age, 55.3 years) was also conducted.

Proved in patients over 50* . . . The response noted in the pilot study is charted above.

*McHardy, G., and Balart, L.: Curr. Ther. Res. *4*:153, 1962.

Dosage: 1 or 2 tablets, swallowed whole with each meal.

Cautions: Federal law prohibits dispensing without prescription. Side effects such as dryness of mouth, blurring of vision, and urinary retention may occur occasionally with large doses. This product is contraindicated in the presence of glaucoma or prostatic hypertrophy. Glutamic acid hydrochloride is usually not given to patients with peptic ulcer.

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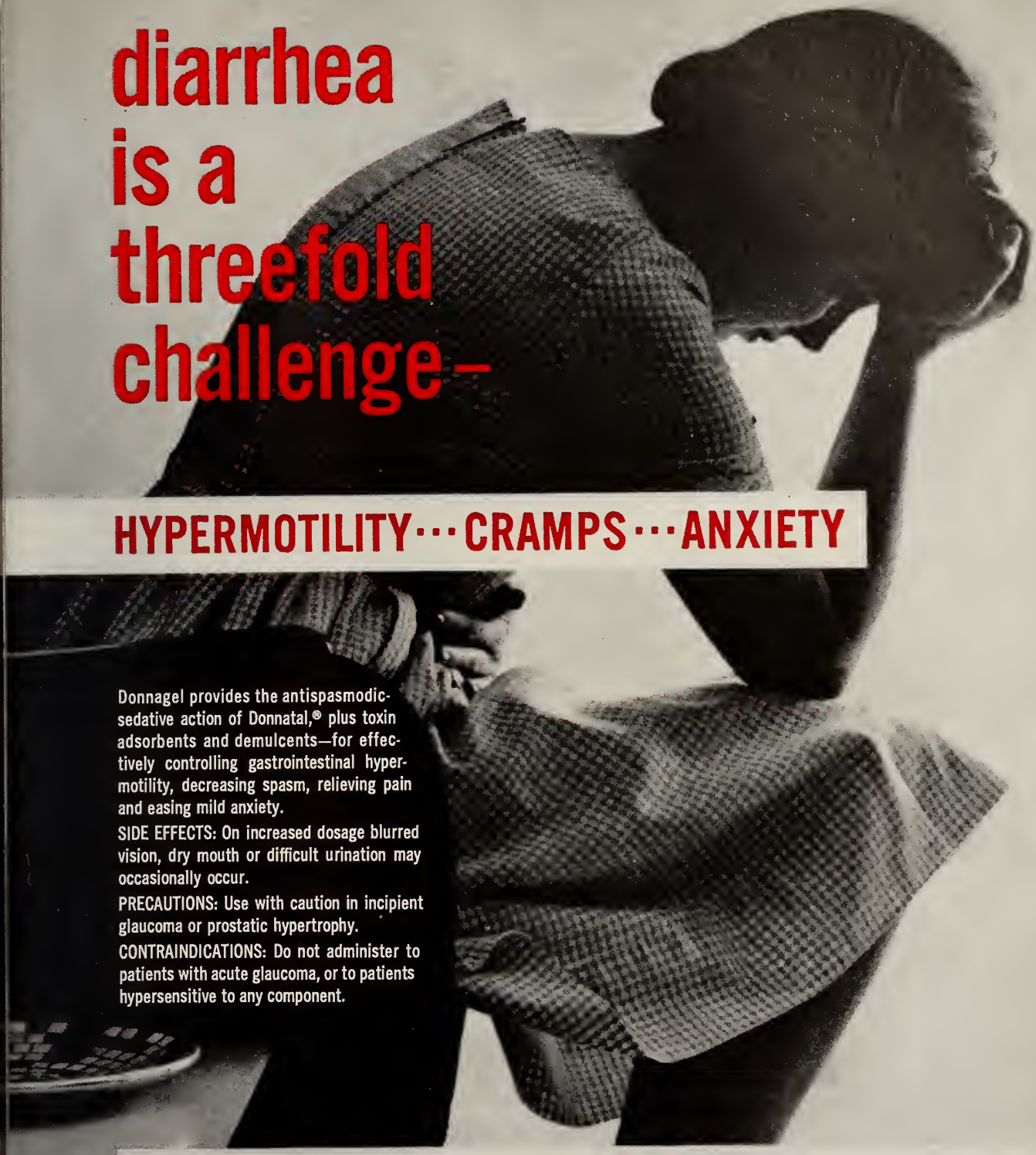
In addition—like so many others these days—he was impressed by the exclusive advantages of Gas. Such as: sizable fuel savings, extra-long equipment life, free 24-hour service, and free semi-annual system checkups.

Do your future plans include building a clinic? Be sure to include Gas air conditioning. For the *complete* reasons why, call an Air Conditioning Specialist at Michigan Consolidated Gas Company. He has some compelling facts to present for your consideration.

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hyoscyamine sulfate	0.1037 mg.
atropine sulfate	0.0194 mg.
hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

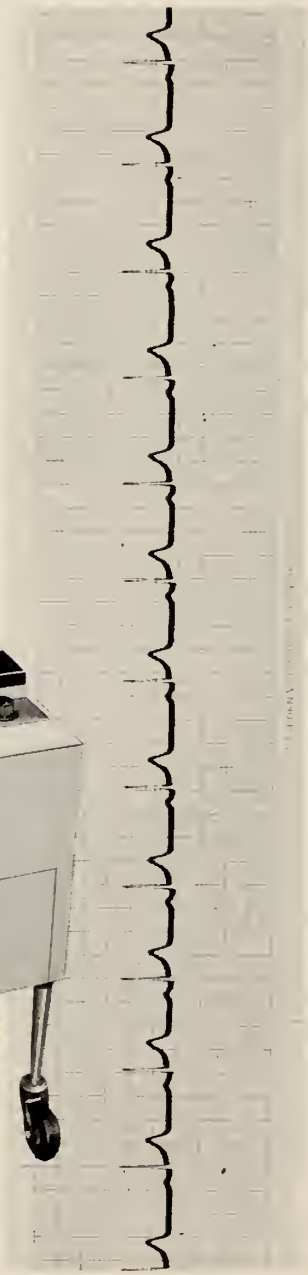
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Health and Medical Care Expenditures Reported

By Richard M. Campau
MSMS Research Director

According to the Health Information Foundation, total expenditures for health and medical care in the United States reached an all-time high of over $29 billion during fiscal year 1960-61, 76 per cent of which was accounted for by private expenditures. When expenditures for direct services* only are considered, the total outlay was $25.7 billion, of which 79 per cent came from private sources.

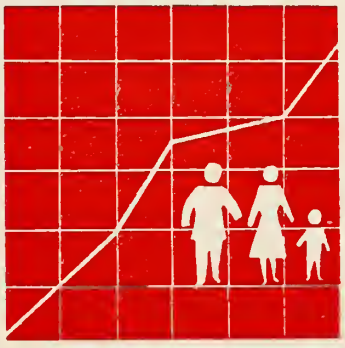
Between the fiscal years 1928-29 and 1960-61 the aggregate expenditure for health care increased 700 per cent, from $3.6 billion to over $29 billion, while the increased expenditures for direct services increased by 680 per cent, from $3.3 billion to over $25.7 billion. Based on a constant dollar (based on consumer prices medical care index) the net increase comes to 270 per cent for aggregate health services and 260 per cent for direct services.

In the fiscal year 1960-61, approximately 44.2 per cent of total public expenditure for health care was contributed by the federal government and 55.8 per cent by state and local governments.

As a proportion of Gross National Product, all expenditures, private and governmental, for health care rose from 3.6 per cent in fiscal year 1928-29 to 5.7 per cent in 1960-61. This increase in the percentage of Gross National Product is the result of government's appropriating an increasing amount of resources for the health of the nation at the same time that consumers have been increasing their spending for health care faster than they have for other goods and services.

As the incomes of American families rose, the amount they spent for all goods and services rose. At the same time, they increased the percentage of their budgets allocated for health needs. Today on a per capita basis, $119 is spent each year for medical services.

*"Direct services" or "personal health services" include all expenditures for health and medical care except those for facilities, research, operating costs of insurance, and general public health activities.



Maryland Blue Cross Rates Rise

The Maryland Insurance Commissioner recently approved an average rate increase of 18.8 per cent for the Maryland Blue Cross and suggested that some government body might be established to control rising hospital costs.

Wholesale Drug Prices Down

Wholesale prices of prescription drugs, as measured by the Firestone Index, dropped 2.6 per cent in 1962 marking the fourth straight year in which prices have declined.

The Index, which included 267 specialties, has shown an overall decline in prices of ethical pharmaceuticals of 12.9 per cent since 1949.

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Poythress, White Section, Page 808 (1963 edition) and Product Identification Section

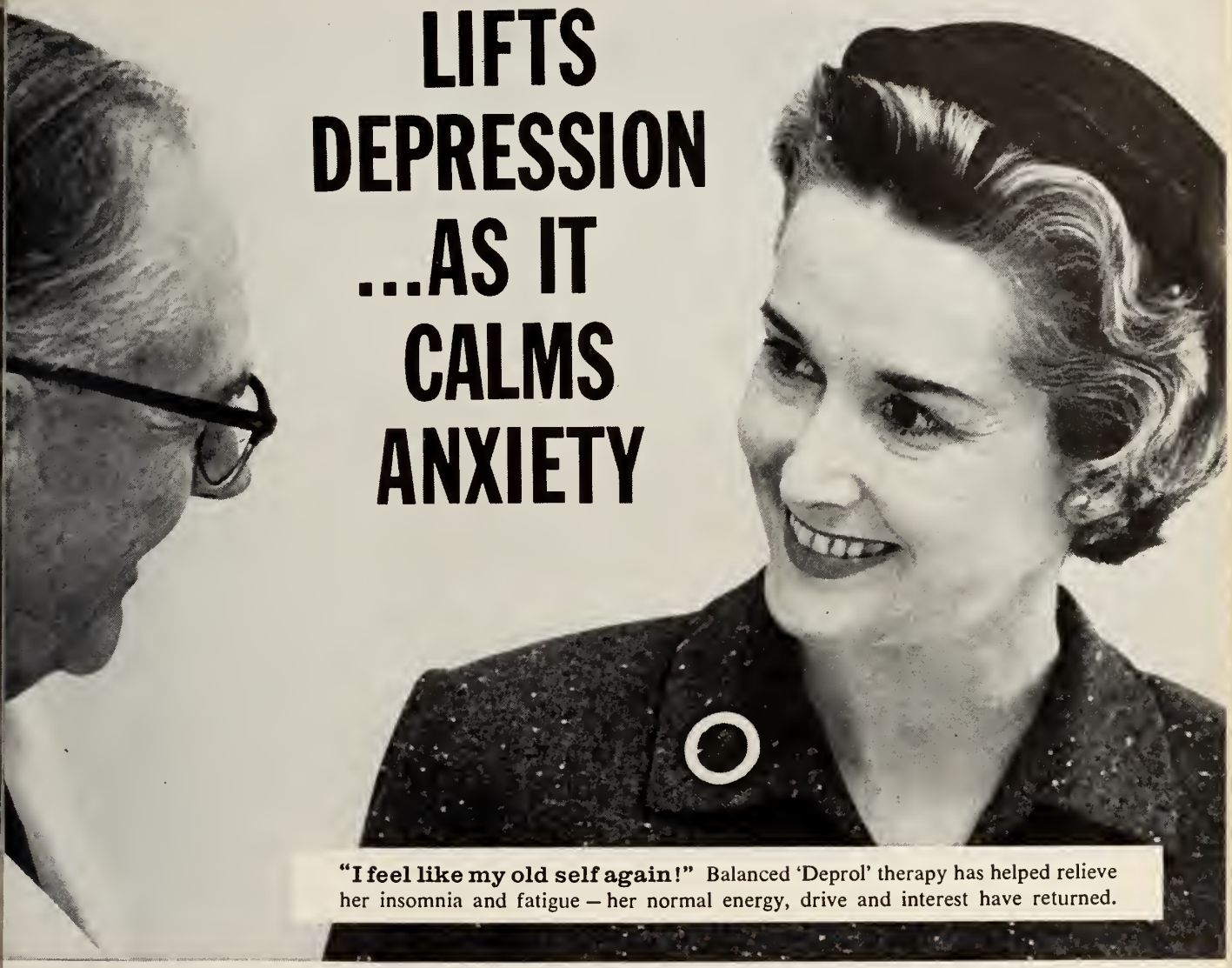
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Usual Dosage: 1 tablet q.i.d. May be increased gradually, as needed, to 3 tablets q.i.d.; with establishment of relief, may be reduced gradually to maintenance levels.

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meprobamate 400 mg.
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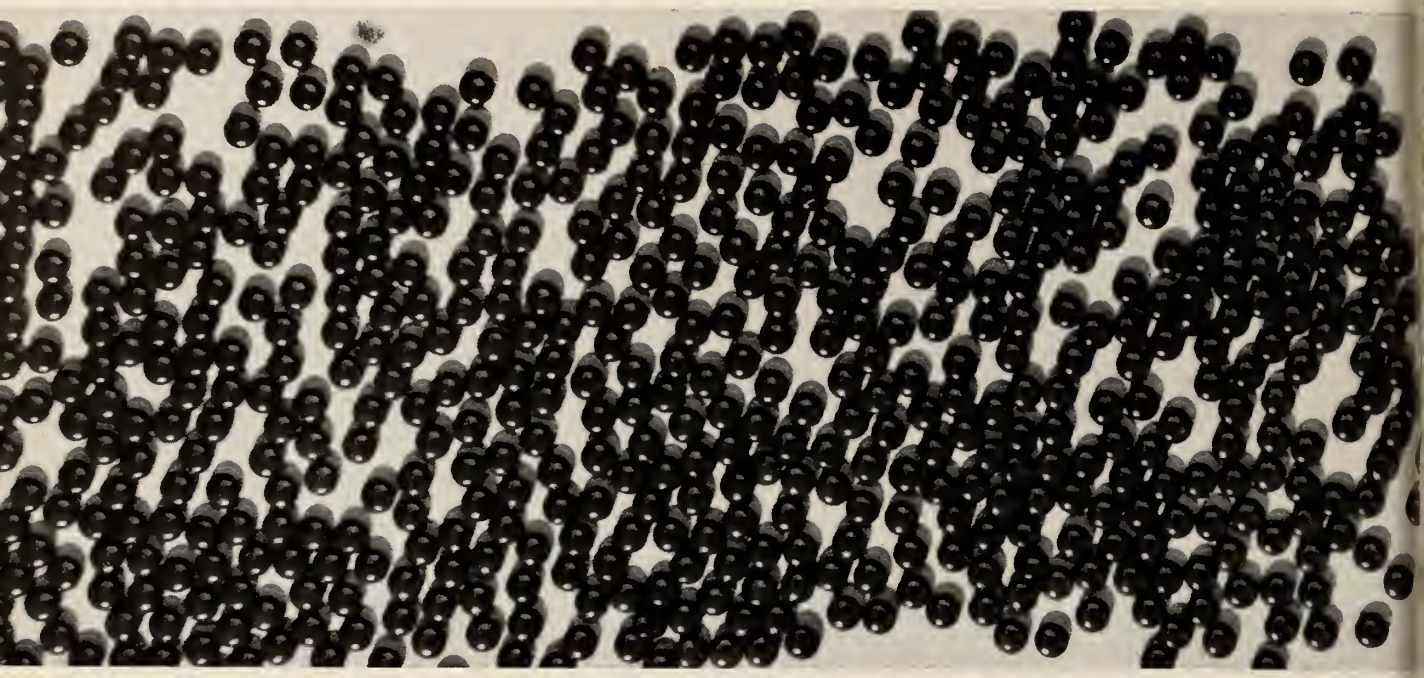
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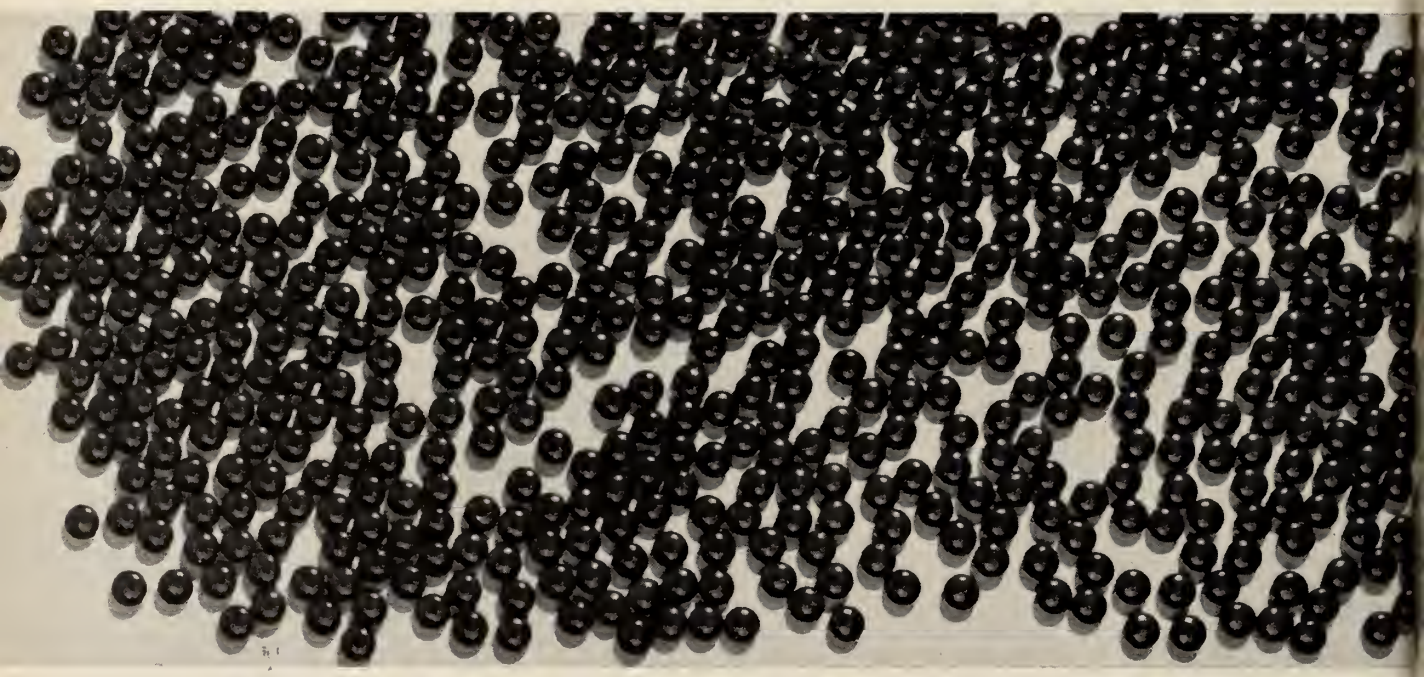
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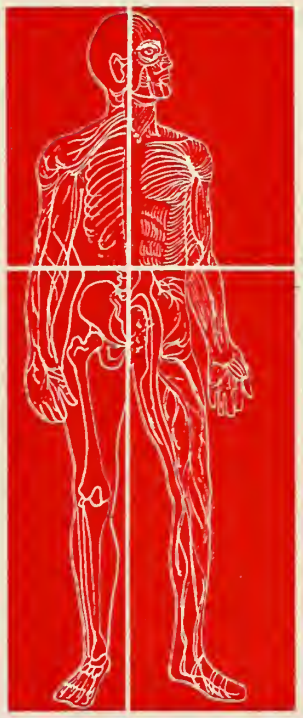
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Richard E. Straith, M.D.
Detroit, Michigan

INFLAMMATION is the localized body reaction to injury, manifested by pain, erythema, and edema, the end result being tissue repair. If these phenomena of inflammation could be reduced, the local discomfort would be alleviated and tissue repair enhanced. This is important in all surgical patients and more so in patients undergoing plastic or cosmetic operations. To find an efficient drug to lessen these phenomena of inflammation, we and others have used many chemical compounds including proteolytic enzymes and steroids and have been generally disappointed with the results.[4,5,6,10] Tandearil is a new anti-inflammatory agent that is non-toxic and most efficient as compared with other anti-inflammatory drugs.[4,5,6,7]

In this survey, we will discuss the therapeutic results obtained with the use of Tandearil in 180 patients undergoing plastic surgery at the Straith Memorial Hospital. There were 360 patients in this series, one-half of which served as controls.



Material and Method

Tandearil is 1-phenyl-2 (-p-hydroxy-phenyl) 3-5-dioxo-4-n-butyl-pyrazolidine-monohydrate, a white powder soluble in alkaline media. It is an orally effective specific nonhormonal anti-inflammatory agent, supplied in enteric coated tablets. The substance is recovered in the urine shortly after administration and up until 24 to 72 hours after cessation of therapy.[1,2,6,7]

Before the administration of Tandearil, careful evaluation of the patient is mandatory if untoward reactions are to be avoided, as this drug is contraindicated in patients with peptic ulcer, systemic edema, drug allergy, blood dyscrasia, or the presence of renal, hepatic or cardiac damage. Blood studies including complete blood count are done before the administration of Tandearil, and in the first few days following its use. The initial preoperative dose is 600 mgm. given in three divided doses on the day before surgery. The same dose is repeated on the day of surgery. The maintenance daily dose thereafter is 400 mgm. given in four divided doses. The drug is given following meals or with a glass of milk to avoid any gastric upsets. In most of our patients, Tandearil was given for five days,

Tandearil (Oxyphenbutazone) was supplied by Geigy Pharmaceuticals, Division of Geigy Chemical Corporation, Yonkers, New York.

From The Straith Clinic, Detroit, Michigan.

TABLE I.

Type of Surgery	Total	F	M	Age	Result as to Pain, Redness and Swelling				Response to Tandearil After			Side Effects
					Excellent	Good	Fair	None	1 Day	2 Days	3 or More	
Rhinoplasty, SMR	127	74	53	16-58	24	96	7		5	79	43	2*
Blepharoplasty	6	4	2	37-68	5	1			1	5		
Rhytidectomy	6	6		49-67	3	2	1			6		
Dermabrasion, face	5	4	1	15-32	5				5			
Tattoo, hemangioma, eyelids & lips	2	2		14-18		2				2		
Facial fractures	4	2	2	20-51		4				4		
Lip scars	3	2	1	14-16		3				3		
Facial scars	6	5	1	15-41	1	5			1	5		
Breast implants and reductions	5	5		24-31	3	2			1	4		
Sponge implants, other	1		1	28		1				2		
Otoplasty	2	2		18-20		2					2	
1st stage Abbe	5	3	2	14-19	4	1			4	1		
Cross-leg pedicle flap	3	2	1	36-47	1	2					3	
SMR-turbinectomy	5	1	4	31-47		5				2	3	
	180	112	68		46 25%	126 70%	8 4%	0	17	112	51	2

*Nausea and vomiting; drug continued.

in a few for 10 to 15 days, at the end of which complete blood counts were done.

Color photographs were taken of all patients in the series on the second and fourth postoperative days and/or the date of cessation of therapy.

Any reaction to the use of Tandearil was noted and recorded in a tabular form.

Results

Tandearil was given to 180 patients undergoing some type of plastic surgery and withheld from 180 control patients. The results (Table I) were evaluated as to pain, edema and redness. These results were compared with the same number of patients taken as controls. The results were classified in four categories: excellent, good, fair, and none.

1. The term "excellent" indicates complete response to the drug whereby the patient required *no* postoperative sedation and the swelling and redness were minimal.

2. The term "good" is used to classify those patients who needed one to two doses of analgesics to control postoperative pain. The edema and redness in these patients subsided after the second day of the use of Tandearil.

3. The term "fair" designates those patients who required narcotics to control the postoperative pain and in whom edema and redness required a week or more to subside completely.

4. The term "none" was used to indicate absolutely no response to the drug; however, there was no instance of this, as shown in Table I.

Comments

The use of Tandearil in patients undergoing plastic surgery proved to be very beneficial. Our results prove that this anti-inflammatory drug is useful in alleviating pain and reducing swelling and redness. Antibiotics were given with Tandearil whenever indicated with no untoward effects.

TABLE II. TOTAL DOSAGE OF NARCOTICS GIVEN TO 90 RHINOPLASTY PATIENTS

Drug	45 Control Patients Total Dose	45 Tandearil Patients	Per Cent Drug Reduction in Patients Taking Tandearil
Demerol	4480 mg.	200 mg.	95
Codeine	122 gr.	73 gr.	40
M.S.	3¼ gr.	1 1/3 gr.	60

Pain.—The marked decrease in postoperative pain was astounding. Table II shows the total postoperative narcotic dosage in 45 consecutive rhinoplasty control patients as compared to 45 consecutive rhinoplasty patients who received Tandearil. Demerol—the most common narcotic used—was reduced approximately 95 per cent. Codeine, which was usually given combined with acetylsalicylic acid, caffeine and acetophenetidin, was reduced about 40 per cent. Morphine sulfate, which was given mainly to allay apprehension when excessive bleeding was present, was reduced approximately 60 per cent.

Tandearil seems to increase the threshold of pain and, in some cases, even to abort the local discomfort following surgery. In the majority of the rhinoplasty cases taking Tandearil, analgesics (salicylates 500 mgm.) in one or two doses were enough to control local discomfort. In about 25 per cent of our cases given Tandearil, no postoperative sedation or analgesia was required.

Swelling and Redness.—In most of the cases in this series, the response to Tandearil was noted two to



Fig. 1 (*left*) Tandearil patients. Note that the size of the palpebral fissure is almost normal and the swelling of the upper lid is minimal in Tandearil patients.



Fig. 2. (*right*) Control patients. Note reduced size of palpebral fissure and considerable amount of swelling in the upper lid of all control patients. Ecchymosis is considerably more pronounced than in the Tandearil patients in Figure 1.



Fig. 3. *(left)* Tandearil patients. Note that the size of the palpebral fissure is almost normal and the swelling of the upper lid is minimal in Tandearil patients.



Fig. 4. *(right)* Control patients. Note reduced size of palpebral fissure and considerable amount of swelling in the upper lid of all control patients. Ecchymosis is considerably more pronounced than in the Tandearil patients in Figure 3.

three days following administration of the anti-inflammatory drug. The swelling and redness subsided on the 2nd postoperative day in the majority of these patients. (Figs. 1 and 3) However, in the controls, the redness and swelling were noted to be more marked as will be seen in the accompanying photographs. (Figs. 2 and 4)

TABLE III. SIDE EFFECTS FOLLOWING THE USE OF TANDEARIL

Side Effects	Absent	Present	
		Drug Continued	Discontinued
Edema			
Gastritis			
Nausea/vomiting		2	
Stomatitis			
Diarrhea			
G.I. bleeding			
Rash			
Other allergy			
Anemia			
Leukopenia			
Purpura			
Jaundice/hepatitis			
	178	2	0

Bleeding.—There would appear to be some connection with the lower incidence of bleeding and the reduction of pain and swelling. Just what this is, we are not prepared to speculate other than to say that a patient without pain is less apprehensive and quieter, both of which could tend to lower blood pressure and reduce generalized oozing. This should be the object of further study.

Side Effects

Table III shows the side effects watched for during therapy with Tandearil. The only adverse reaction was some nausea with vomiting in two patients, but in no instance was it necessary to discontinue the drug. Antibiotics were given when indicated with no untoward effects.

Summary

Tandearil is an effective non-toxic anti-inflammatory drug that has proved very useful in plastic surgery. Tandearil reduces the phenomena of inflammation, alleviating pain and reducing edema and redness to such a degree that we are now using it with guarded enthusiasm for all adults undergoing plastic surgery.

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Age and Auto Accidents

The accident index for drivers aged 60 to 69 years is below the national average, the index for those above 70 being equal to the national average. Donald P. Kent, Ph.D., Special Assistant for Aging, Department of Health, Education and Welfare, recommends stricter physical and psychological testing for all drivers, not exclusively for the older age group as proposed by the National Safety Council. "To apply any test to one age group only seems inconsistent when the same factors—impaired vision and hearing, chronic diseases and physical impairments, slowed perception, response, learning, and other mental functions—are applicable to other age groups as well."—*Clinical Medicine*, January, 1963.

Heart Disease, Cholesterol Level And Diet of Rural Men

Jean K. Boek, Ph.D.
Walter E. Boek, Ph.D.
New York, New York

ONE RESPONSE to the rise in mortality from cardiovascular-renal diseases, which accounts for about 55 per cent of all deaths, has been a marked increase in research on the problem by scientists representing a variety of disciplines. In spite of work by these biochemists, physiologists, epidemiologists and others, little clear-cut evidence exists as yet to show how any one factor causes or even contributes to development of coronary artery disease in man.[1]

A number of investigations in recent years have been concerned with relation of heart disease to diet, serum cholesterol levels, age, sex, stress and occupation and have led to tentative, often conflicting results. One difficulty has arisen from the type of population studied. Where research has concentrated on persons already known to have cardiovascular disease, it often has been done with institutionalized or other captive populations, removed from participation in ordinary daily existence, or with groups lacking adequate controls. On the other hand, where the effort has been to study prevalence of cardiovascular impairments in all residents of an area, samples have had to be large enough to secure a sufficient number with the disease for meaningful comparisons with the rest.

Occasionally, it has been possible, as in the present work, to resolve the dilemma of accessible, non-participating or non-representative groups versus a random sample of a whole community by studying persons who carry on their ordinary activities and who at the same time are more likely than the general population to have cardiovascular ailments. A population that met both of these requirements were men whom the authors had interviewed in their homes in 1950. At that time, it consisted of 185 men who were heads of farm families living in or near Hillsdale County, Michigan. One hundred of them were a sample of all borrowers in the Farmers Home Administration (FHA) program since its beginning in that county, who had remained in farming and whose families were unbroken through death, separation or divorce. During the 1950 interview, these 100 farmers had been asked about the kind of help received from the FHA, their farming operations, community participation, level of living, schooling, health and diet. They were also asked to name all families they knew before they had received their FHA loan who were similar to them in size and general economic status, who were still in farming and who had not had an FHA loan, in order that a control group for comparative purposes might be obtained. From all the families named by the 100 FHA families, 85 were located and interviewed with similar questions.[2]

Because extensive data were available on these rural men in 1950, it was felt that a second study would provide valuable insights as to the prevalence of cardiovascular impairments and the relationship of these conditions to other aspects of their life. Therefore, in 1957, 171 of the men were interviewed again to learn about their health during the years between 1950 and 1957, and their current diet, level of living and occupational activities.*

Questions about their health included, in the fol-

Doctor Jean Boek is Director Teacher-Parent Communication Research, Bank Street College of Education, New York, New York.

Doctor Walter E. Boek is Consultant, Bureau of Social Science Research, Inc., Washington, D. C.

*Of the remaining 14 men, five had died, four would not consent to the second interview, three answered some but not all questions and two who had moved into other States could not be found there.

Partial support for this research came from the New York State Department of Health through the interest of Dr. Herman E. Hilleboe, Commissioner. Funds for serum cholesterol level determinations were given by the School of Public Health, University of Michigan, and were done under direction of Dr. Frederick H. Epstein. Services and facilities during field work were provided by Hillsdale College and Russell Sage College. Doctors Arthur W. Strom, Cardiologist, and H. Frazyer Mattson, President of the Hillsdale County Medical Society, in particular, gave invaluable assistance. Others who aided the work were Mr. John Rasmussen, Administrator, Hillsdale Community Health Center, Mrs. Dolores Boyd, R.N., who collected blood samples, and officers of the Michigan Department of Public Health. Of paramount importance to the project was the willingness of the men to be interviewed and to provide the blood samples for serum cholesterol determinations.

lowing order, (a) present weight and (b) height, and whether or not they had any of the following conditions since 1950: (c) loss of weight, (d) trouble getting to sleep at night, (e) worry, (f) distress, pain or an uncomfortable feeling in their chest when walking or going up steps, (g) chest pains after meals, (h) being forced to stop to rest while walking, (i) repeated swelling of ankles, (j) persistent headaches, (k) sortness of breath, (l) cough not from a cold, (m) dizzy spells, (n) being tired more easily in the last six years, (o) high blood pressure, (p) hardening of the arteries, (q) a heart condition of any kind, and (r) change of work because of health. Affirmative replies to chest pains, shortness of breath, cough, hypertension, atherosclerosis and heart condition were followed by requests to describe these more fully, and for the latter three conditions, how they first learned about them and if a doctor had told them. Additional data about cardiovascular impairments were secured from the physicians they said had cared for them. For their diet, a record was made of all food eaten and liquids drunk during the entire day prior to that of the interview, in a fashion similar to that done in 1950. Level of living, as a gauge of how they spent their money, consisted of an inquiry about facilities such as water, heating, appliances and mass media in their homes. Effort was made to include items that some, but not everyone, would have and to assign scores reflecting relative expense or difficulty of procural. For example, central heating was assigned a higher score than were space heaters. Points for individual items were then totaled to give a level of living score.

In addition to the interview, each man was asked to give a blood sample for serum cholesterol determinations. Such determinations were made for 139 of the 171 men interviewed and one more who refused to be interviewed. Blood samples taken from two others were not large enough for analysis. Refrigerated sera were analyzed within two weeks of collection by the method of Abell et al.[3] The technical error between duplicate determinations in different runs was 5.2 mg. per cent in the laboratory where the tests were performed, comparing favorably with results obtained in other institutions.[4]

TABLE I. COMPARISON OF SERUM CHOLESTEROL LEVELS AND AGE OF 140 MEN INTERVIEWED IN 1957

Serum Cholesterol Level mg. %*	Age†					
	30-39	40-49	50-59	60-69	70-79	Total
100-149	—	1	—	—	—	1
150-199	5	11	3	1	1	21
200-249	6	28	23	10	4	71
250-299	5	13	10	6	1	35
300-349	—	—	3	3	—	6
350-399	1	3	2	—	—	6
Total	17	56	41	20	6	140

*Range was 142-395 mg. per cent. Mean was 240 mg. per cent.
†Mean age was 44 years.

Analyses and Results

Serum Cholesterol Results.—The range of total serum cholesterol values for the 140 men was 142 to 395 mg. per cent, with a mean of 240 mg. per cent. The possibility suggested itself that since determinations could not be made for all the men interviewed the second time, that the 140 might not be representative of all 171. A check on this using data from both interviews showed, however, that the 140 did not differ significantly from the 31, for whom determinations could not be done, on key characteristics such as community participation, level of living, net family income, schooling, age and replies on the Symptoms Schedule used as an indicator of health in 1950.[5] The lack of differences between the groups lent confidence that these factors did not influence in some systematic fashion the men's decision to give or not give a sample of blood, and that the 140 were, therefore, adequate spokesmen of the whole group.

Comparison of serum cholesterol levels with age of the 140 men was made to test the hypothesis that they would increase with age, but, as Table I indicates, no tendency existed for older men to have higher levels than younger men.

The day's diet of the men was analyzed by number of calories, total grams of fat and grams of protein,[6] since these components at present, more than others, appear to be of greatest interest with respect to heart disease. It was hypothesized that as the men's intake of each increased, their serum cholesterol levels

TABLE II. AFFIRMATIVE REPLIES TO QUESTIONS ABOUT HEALTH FROM 1950 TO 1957 BY ALL RESPONDENTS AND BY THOSE CLASSIFIED AS HAVING AND NOT HAVING A CARDIOVASCULAR AILMENT

Health Questions (According to Order of Inquiry in 1957 Interview)	Affirmative Replies						Significance of Difference Between Cardiovascular and Non-cardiovascular Groups (t test)
	Total Group (N=172*)		Cardiovascular Impairment Group (CV) (N=22)		Men Not Having a Heart Condition (Non-CV) (N=150)		
	No.	%	No.	%	No.	%	
(a) Trouble in getting to sleep at night	34	20	6	27	28	19	Not significant
(b) Distress, pain or uncomfortable feeling in chest when walking or going up steps	18	10	6	27	12	8	Significant $P<0.01$
(c) Pain in chest after meals	12	7	5	23	7	5	Significant $P<0.01$
(d) Forced to stop when walking in order to rest	31	18	10	46	21	14	Significant $P<0.01$
(e) Repeated swelling of ankles	12	7	3	14	9	6	Not significant
(f) Persistent headaches	32	19	8	36	24	16	Significant $0.05> P>0.01$
(g) Shortness of breath	63	37	16	73	47	31	Significant $P<0.01$
(h) Cough not from a cold	47	27	7	32	40	27	Not significant
(i) Dizzy spells	32	19	7	32	25	17	Not significant $P<0.10$
(j) Tired more easily in last six years	110	64	18	82	92	61	Not significant $P<0.08$

*Includes one man who answered these questions but not all of the others in the interview.

would be higher. Testing each of the three hypotheses for linear relationship with coefficient of correlation (r), however, revealed no association between serum cholesterol levels and total calories (r=.039), grams of fat (r=.064) and grams of protein (r=.029). Thus, the postulated positive correlations were not found for this group.

Comparison of Men With and Without Cardiovascular Impairment.—In the interview, 12 of the men said they had a heart condition of some kind. Medical records available for 90 of the total group showed that 18 had had a heart attack or other cardiovascular ailment. Eight of the 12 and of the 18 were the same men. In determining how to classify the men as to whether or not they had some cardiovascular impairment, the methods of another study offering a parallel situation were followed here. During research on the epidemiology of automotive accidents, results of a test of what could be learned in interviews and from official records showed a substantial overlap. At the same time it was found that some people told interviewers about accidents that should have been on record and were not, whereas other respondents did not mention accidents that appeared in official files.[7] The best classification of drivers into the accident or non-accident columns, therefore, made use of a combination of interview and record data. On the basis of that research, as well as the fact that a large proportion of the men in the present study had not been seen by physicians in years, the decision was made to categorize as having some cardiovascular impairment all those mentioned as such in the interviews and on the records, giving a total of 22: 12 plus 18 minus 8. Comparisons between the 22 and the rest of the 171 could then be made by (1) serum cholesterol levels, (2) weight, (3) other health conditions, (4) worry, (5) diet, (6) other eating habits, (7) smoking and (8) level of living.

1. *Serum Cholesterol Levels.*—Since determinations had not been done for all men, comparison here was limited to 12 of the men classified as having a cardiovascular impairment (CV group) with 128 of those in the non-cardiovascular impairment column (non-CV group). Mean mg. per cent serum cholesterol level for the 12 CV's was 266.0 compared to 236.4 mg. per cent for the 128 non-CV's. Since difference between the 266.0 and 236.4 was significant at between the one and five per cent levels of probability according to the t test, it meant that men in this study with cardiovascular ailments had higher serum cholesterol levels than men classified as not having those conditions.

2. *Body Weight.*—It was hypothesized that the 22 men having some kind of heart condition would average greater body weight than the 149 not thus classified, but no significant difference in mean weights was found. In fact, the mean of 161.3 pounds for the CV group was less than the mean of 171.7 pounds for the non-CV, a tendency opposite of that postulated.

3. *Other Health Conditions.*—Table II shows the number of all men, and then of those in the CV and non-CV groups, who gave affirmative replies to the health questions in the order in which they were asked. Significance of difference between percentages of CV and non-CV's who gave these replies were determined with the t test.

Considering differences between the CV and non-CV's for a moment, it can be seen that significantly more of the CV group than of the others experienced distress or the like in their chest when walking or

going up steps (item b), had pain in their chest after meals (item c), were forced to stop when walking in order to rest (d), had persistent headaches (f) and shortness of breath (g). There was a slight tendency that was not significant, for more of the CV's to have dizzy spells (i) and to have become tired more easily in the last six years (j). Not significant were trouble in getting to sleep at night, repeated swelling of ankles and cough not from a cold.

TABLE III. REPLIES TO THE QUESTION, "DO YOU WORRY MORE ABOUT THINGS OR WORRY LESS ABOUT THINGS THAN OTHER PEOPLE DO?"

By total group and by men with and without a heart condition.

Replies	Total Group		Cardiovascular Impairment Group (CV Group)		Men Not Having A Heart Condition (Non-CV Group)		Significance of Difference in Proportions Between CV and Non-CV Groups
	No.	%	No.	%	No.	%	
More	38	22	9	41	29	19	Significant P<0.05
Less	69	40	5	23	64	43	Not significant
Average, normal, "everyone has worries"	56	33	6	27	50	33	Not significant
I don't know	9	5	2	9	7	5	Not significant
Total	172*	100	22	100	150	100	

*Includes one man who answered this but not all questions in the interview.

If the whole group is looked at, it can be seen that tiring more easily is cited by almost two-thirds of the total; shortness of breath by over one-third; cough not from a cold by 27 per cent; trouble in getting to sleep at night by a fifth; persistent headaches, dizzy spells and forced to stop when walking in order to rest, each by almost one-fifth.

4. *Worry.*—The question "Do you worry more about things or worry less about things than other people do?" was asked as a means of getting a subjective measure of mental stress for these men. It is interesting to note in Table III that significantly more of the CV than of the non-CV group said they worried more than others did, but that the majority of the total group either said they worried less, an average amount, or that "everyone has worries."

5. *Diet.*—Calculation of total calories, grams of fat and of protein for men with and without cardiovascular impairments showed no significant differences in means between the groups, as indicated in Table IV. It should be pointed out, nevertheless, that the CV group had a somewhat lower average fat intake, slightly higher protein average, and, related to this, a smaller mean for total calories.

6. *Other Eating Habits.*—Upon completion of questions about the previous day's diet, the men were asked if they had had to change what they could eat or drink during the past six years. Affirmative replies were given by 41 per cent of the CV group compared to only 11 per cent of the non-CV, a difference significant at the 1 per cent level.

In contrast to this, the two groups did not differ significantly in whether or not they removed fat from meat before eating it. Somewhat more of the CV group (36 per cent) than of the others (32 per cent) removed the fat, which is in line with the slight tendency for CV's to average less fat in their diet.

TABLE IV. COMPARISON OF MEN HAVING A HEART CONDITION OF SOME KIND WITH THE REST INTERVIEWED IN 1957 BY THREE MEASURES OF DIET

Dietary Factor	Cardiovascular Impairment Group (CV Group)		Men Not Having A Heart Condition (Non-CV Group)		Significance of Difference Between Means	
	No.	Mean	No.	Mean	t	Probability
Fat (in grams)	22	146.5	149	155.1	.561	P=0.50
Protein (in grams)	22	105.8	149	102.2	.336	P>0.70
Calories	22	2903.4	149	2987.2	.340	P>0.70

7. *Smoking.*—Because of the mounting evidence indicating some association between smoking and condition of the heart, the hypothesis of this study was that men having a heart condition would more likely be smokers than the others. Actually the opposite was found. Only 36 per cent of the CV group smoked in contrast to 64 per cent of the others, a difference

significant at the five per cent level. When the total group was considered, 60 per cent were found to be smokers.

8. *Level of Living.*—With the level of living score considered a reflection of style of life, it was hypothesized that men with a cardiovascular impairment would have a lower score than the others. Findings showed the range of scores for the total group to be three to 40 with the CV mean being 23 compared to a significantly higher average of 27 for the non-CV group. Thus support was given to the hypothesis.

Summary

In this study, 171 men in rural Michigan were reinterviewed about their health, diet and level of living some seven years after they were first interviewed about their participation in the Farmers Home Administration, their farming operations, community participation, schooling, health and diet.

One hundred and forty of the men in the follow-up also gave a blood sample for serum cholesterol level determinations. Comparison of the 140 with the others interviewed showed no significant differences between them on a number of characteristics. Range of total serum cholesterol values for the 140 men was 142-395 mg. per cent, with a mean of 240 mg. per cent. Neither age nor the dietary components of total calories, grams of fat, and grams of protein were found associated with serum cholesterol values.

Men were classified as to whether or not they had a cardiovascular impairment on the basis of their replies to a series of questions as well as on physician records. A significantly higher mean serum cholesterol level, 266.0 mg. per cent, was found in the cardiovascular impairment group (CV group) than for the others, 236.4 mg. per cent. With respect to body weight, the CV group averaged about 11 pounds lighter, or 161 pounds compared to 172 pounds for the others. CV answers to other questions about their health, that did not influence their being classified as a CV, showed they had experienced more chest pain, headaches and dyspnea than the others but were not different in sleep patterns, having swollen ankles or cough not from a cold. Significantly more of the CV's thought they worried more than other people did, but their intake of fat, protein and total calories did not differ from the others. Significantly more of the cardiovascular impairment group had to change what they could eat in the six years prior to the interview, but were not different in whether or not they cut fat off meat before eating it. Fewer CV's smoked and their level of living was lower than the others.

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Wise Advice

No one on the health team or intimately associated with the health team is unaffected by regulations, legislation or other developments affecting any member of the team any more than they are free of the effects of modern chemotherapy, surgery or sanitation.

Make your views known on matters as they unfold, not only in medical publications, but also in other media, in political action, in representations to your legislators, and in other ways. It is as important to support constructive measures as it is to criticize proposals or events which make you unhappy.—Excerpt from address by AUSTIN SMITH, M.D., President Pharmaceutical Manufacturers Association, Annual Meeting, American Medical Writers Association.

Clinical Evaluation of Magnesium 3,7-Dimethylxanthine Oleate in the Treatment of Hypercholesterolemia

Double-Blind Study of 52 Cases for a Period of Six Months

Frank LaCamera, Jr., M.D.
H. Milton Rogers, M.D., F.A.C.P.
St. Petersburg, Florida

THE USE of Athemol (magnesium 3,7-dimethylxanthine oleate) as an agent to reduce blood cholesterol in man has assumed increasing importance in the past year. A double-blind study was planned to evaluate the effect of this drug in patients who had known hypercholesterolemia.

Chemistry and Pharmacology

The generic name of Athemol is magnesium 3,7-dimethylxanthine oleate, of which each tablet contains 200 mg. The recommended dosage is one or two tablets three times daily.

Studies in Austria, where the drug originated, indicated that Athemol increases the solubilizing power of the blood for cholesterol and lipoproteins, thus preventing the deposition of these substances in the intima. Blood chemical investigations show that the lipid fractions, total lipids, and total cholesterol of the blood are reduced. These results suggested that arteriosclerosis associated with hypercholesterolemia may be treated etiologically.[1]

Theoretically, Athemol may aid in resolubilizing cholesterol deposits in the vascular walls. This effect, however, remains to be proved.

Previous Reports

A report from Vienna in 1957 covered the use of Athemol in 15 cases of arteriosclerosis for a period of six weeks. The following results were observed: (1) The drug was well tolerated. (2) It improved the subjective symptoms. (3) Systolic and diastolic blood pressure were reduced. (4) The total blood cholesterol level, particularly the cholesterol ester fraction, was frequently lowered.[2]

In 1958, another report from Vienna was based on the treatment of 117 cases of cerebral arteriosclerosis with Athemol for a period of six months. Symptomatic relief was observed as follows: "pressure in the head" 92 per cent, depression 91 per cent, headache 84 per cent and dizziness 57 per cent. There were no side effects. After medication for two to three months there was a constant demonstrable reduction of the blood cholesterol level.[3]

An American study reported in 1958 showed that Athemol increases the colloidal stability of the serum. In a group of 23 men with hypertension and atherosclerosis who were treated for periods up to six weeks, the systolic blood pressure dropped an average of 20-25 mm. Hg. and the diastolic 10-15. The patients reported a sense of well-being and there were no untoward effects. Blood cholesterol levels in 11 cases dropped 10-15 per cent, with no instance of increase.[4]

Present Study

The present study was designed to evaluate the use of Athemol as an anticholesterolemic agent under normal home conditions without specific dietary restriction.

A random selection was made of a group of 52 hypercholesterolemic patients from a large practice of internal medicine. In all cases, the serum cholesterol reading was over 250 mg. per cent which is regarded as the top limit of normal in our laboratory.

A double-blind type of study was instituted for a period of six months. The medication used was Athemol* in a dosage of two tablets three times daily.

Measures were taken to avoid voluntary low cholesterol diets. During the entire study period, the patients were instructed to continue the same general

*Athemol tablets were supplied by Meyer Laboratories, Inc., of St. Clair Shores, Michigan.

dietary habits as before. In four cases, this program represented low cholesterol diets. The other 48 patients were instructed to avoid excessive fats above their customary intake and also excessive restriction of fats.

The blood cholesterol reading was determined each month during the trial period. An electrocardiogram was taken at the start and conclusion. Every third patient underwent additional studies initially and at two-month intervals to determine any effect the medication might have on liver function, renal efficiency, and bone marrow.

Nine patients failed to complete the study for reasons which will be explained. These cases were not included in the evaluation of results.

Results

Forty-three patients were maintained on the full dosage of 2 tablets, drug or placebo, three times daily with meals for a total period of six months. The tablets were keyed and their identity was not known until the end of the study.

It was found that 29 patients had taken Athemol and 14 the placebo.

The serum cholesterol reading of the 43 patients before treatment with Athemol averaged 331 mg. per cent. There was an average fall of 31 mg. per cent during the entire six months in 23 cases, with the percentage reduction toward normal being 38 per cent. Six cases showed an average rise of 29 mg. per cent with a percentage increase of 32 per cent above the initial cholesterol level (Table I).

Most patients said that they felt better while taking Athemol but were not more specific. This improved well-being was particularly apparent in those patients who previously had been on cholesterol-lowering agents.

TABLE I. ATHEMOL GROUP—SERUM CHOLESTEROL VALUES

Sex	Start (mg. %)	Fall (mg. %)	Per Cent Fall Toward Normal	Rise (mg. %)	Per Cent Rise
M	333	150	127	—	—
M	358	—	—	55	34
F	331	19	23	—	—
M	285	—	—	5	13
M	379	23	18	—	—
M	372	79	65	—	—
M	357	38	36	—	—
F	376	—	—	57	31
M	338	32	36	—	—
F	365	6	5	—	—
M	304	37	69	—	—
F	307	21	37	—	—
F	386	33	24	—	—
M	276	—	—	19	42
F	357	14	13	—	—
M	295	22	49	—	—
M	294	10	23	—	—
M	282	—	—	18	56
F	362	18	16	—	—
M	352	—	—	3	3
F	304	14	26	—	—
M	346	37	39	—	—
F	334	12	14	—	—
M	311	14	23	—	—
F	363	21	19	—	—
F	360	42	38	—	—
M	275	47	109	—	—
F	306	11	20	—	—
F	286	11	31	—	—
Averages	331	31	38	29	32

In the 14 controls, six showed a fall in cholesterol levels from an average of 307 to 290 mg. per cent or 30 per cent toward normal. Seven showed an average rise of 26 mg. per cent or 42 per cent above the starting level. One patient showed no change while taking the placebo (Table II).

The results indicate that Athemol may be useful in combating hypercholesterolemia.

The full period of treatment was not completed in nine cases for the following reasons: four patients were uncooperative, two developed generalized itching (one on placebo), one died of acute coronary occlusion, one developed Bell's palsy, and one hysterical aphonia (on placebo). The intercurrent conditions are regarded as fortuitous.

No Side Effects

Urinalyses, complete blood counts, blood chemistry and electrocardiograms showed no abnormalities. There was one case of pruritus with Athemol and one with the placebo. (Table III).

TABLE II. PLACEBO GROUP—SERUM CHOLESTEROL VALUES

Sex	Start (mg. %)	Fall (mg. %)	Per Cent Fall Toward Normal	Rise (mg. %)	Per Cent Rise
M	262	—	—	43	78
F	264	—	—	16	53
F	275	4	16	—	—
M	307	—	—	30	34
F	355	24	23	—	—
F	289	55	106	—	—
F	334	—	—	25	23
M	328	—	—	26	25
M	311	20	32	—	—
M	270	10	50	—	—
F	265	—	—	29	66
M	324	1	1	—	—
F	324	—	—	13	18
F	300	0	0	—	—
Averages	307	17	30	26	42

TABLE III. ATHEMOL TOXICITY STUDY

Drug	Sex	BUN	TP	Alb.	Glob.	Thy. Turb.	CBC	Urine
A	M	12-20	7.3-6.6	4.16-4.72	3.14-1.93	9-4.6	NC	NC
A	M	16-14.5	6.4-7.4	4.8 -5.0	1.5 -2.4	6.3-4.2	NC	NC
P	F	19-21	6.9-6.5	4.9 -4.4	2.25-1.74	3.2-1.3	NC	NC
A	M	16-21	7-6.3	4.8 -4.28	2.6 -1.9	5.2-3.8	NC	NC
P	F	9-14	6.9-7.2	4.3 -5.04	2.77-2.16	4.9-3.6	NC	NC
A	M	17-12	7.3-6.8	5.12-4.16	1.68-3.14	4.9-3.2	NC	NC
A	F	9-14.5	7.7-7.2	5.2 -4.96	2.5 -2.2	2.9-1.9	NC	NC
P	F	14-22	6.9-7.05	4.56-3.9	2.34-3.0	19.8-7.8	NC	NC
P	M	7-8.75	7.5-7.05	5.3 -4.7	2.0 -2.8	13.8-5.6	NC	NC
A	M	13-16	7.5-7.2	5.3 -5.0	2.5 -2.2	2.0-2.27	NC	NC
A	F	29-15	8.2-7.3	4.96-4.4	3.24-2.42	1.9-2.0	NC	NC
A	M	13.75-8.0	7.3-6.9	4.4 -4.8	2.9 -2.1	2.9-1.6	NC	NC
A	F	8.75-17	7.3-6.9	4. -4.56	3.3 -2.4	11.5-6.0	NC	NC
P	F	14-18.5	6.9-6.3	4.3 -5.04	2.55-1.82	2.2-1.6	Eos 3-10	NC
A	F	9.25-17	7.4-6.7	4.5 -5.2	2.5 -1.8	4.4-1.8	NC	NC
P	F	8-14	7.7-8	4.7 -4.28	3-3.62	7.6-3.9	NC	NC

Normal values
BUN 8-15 mg.%
Total protein 6-8.2 gm.%
Albumin 3.8-6.7 gm.%
Globulin 1.2-3.2 gm.%
Thymol turbidity 0-5 units

Key
NC—No change
A—Athemol
P—Placebo

Discussion

The role of hypercholesterolemia in the pathogenesis of atherosclerosis is still controversial. Most internists and cardiologists, however, favor an attempt to keep the blood cholesterol within normal limits by means of dietary and therapeutic measures.

The question whether hypercholesterolemia may be a metabolic defect or merely a dietary indiscretion, or a combination of both, must be established in each individual case in order to determine the most effective treatment. Whereas the cholesterol content of the food may be measured accurately for patients on restricted diets in hospitals or carefully controlled situations, the average patient is unable to follow such instructions precisely at home. The results of the present study are therefore of interest, because they indicate what may be accomplished by suitable therapy in ambulatory cases of hypercholesterolemia.

It is apparent from this clinical study that Athemol can be a safe and useful drug in attempting to lower blood cholesterol levels. That it is not effective in all cases is definitely illustrated by this study. However, the addition of a low cholesterol diet undoubtedly would enhance the effectivness of the drug in most instances. The lack of side effects, either subjective or objective, further encourages the use of Athemol.

Summary

Results of a double-blind study in 52 cases of hypercholesterolemia indicate that oral treatment with Athemol (magnesium 3,7-dimethylxanthine oleate) provides a safe and useful means of reducing the blood cholesterol in most cases. In 23 of 29 patients treated with Athemol without dietary restrictions, there was an average fall of 38 per cent toward normal cholesterol levels. Six patients showed an average rise of 32 per cent. Urinalyses, hematological and liver function studies, and electrocardiograms were negative. There were not side effects. The possibility of treating hypercholesterolemic arteriosclerosis with Athemol deserves further long-range study.

(References are on Page 608)

A Comparative Evaluation of Two Antihypertensive Preparations

Antonio Ramos, M.D.
J. Walden Retan, M.D.

Detroit, Michigan

RECENTLY, we have participated in a clinical evaluation of a new hypertensive agent, 6-chloro-3,4-dihydro-3-(5-norboren-2-yl)-7-sulfamoyl-1,2,4-benzothiadiazine-1,1-dioxide (Cyclothiazide, Lilly). This relative of chlorothiazide has been found, in preliminary trials, to be potent in doses of 1 to 2 mg. a day. If its efficacy were established, this magnitude of potency should be of advantage in the formulation of tablet combinations of antihypertensive agents.

In our study, we made the assumption that thiazide and reserpine are effective antihypertensive agents. We believed that the most useful clinical study would be a comparison of the effectiveness of a tablet containing 2 mg. Cyclothiazide, 0.25 mg. Sandril (reserpine, Lilly) and 500 mg. of potassium chloride, subsequently referred to as compound A, with a more well-known compound, Serpasil-Esidrix No. 2, containing 50 mg. Esidrix (hydrochlorthiazide Ciba) and 0.1 mg. Serpasil (reserpine Ciba), subsequently referred to as compound B, each given twice a day. To increase the rigorousness of the trial the agents were tested in hypertensive patients uncontrolled by antihypertensive regimens that included thiazide and Rauwolfia compounds.

The study established an effectiveness of cyclothiazide, Sandril and potassium chloride equivalent to that of Serpasil-Esidrix No. 2 in the doses used. We were somewhat surprised to observe that the treatment period resulted in a significant lessening of the blood pressure in some patients who had previously been uncontrolled on similar regimens. There was no perceptible difference between the two compounds in their side effects.

Methods

Patients were selected from the hypertension and medical clinics of Detroit Receiving Hospital on the basis of established hypertension not adequately controlled by the medication given them, and of willingness to participate in the study. They were classified as to the severity of their hypertension according to Smithwick's Classification (Table I) from information in hospital records and assigned at random to one of the two treatment groups. Patients in each group were given medications "A" and "B" in one of two sequences, ABBA or BAAB, for a total of four successive weekly periods. At the start of the study and after each week of treatment the patients were seen to permit volunteering of significant subjective reactions and their blood pressures were measured three times in the sitting position, from which an average value was tabulated. Subsequently, blood was drawn for determination of their blood urea nitrogen, serum sodium, potassium and uric acids in the routine hospital laboratory, and their medications changed.

At the start of the study, all other thiazide and Rauwolfia treatment was stopped. Digitalis, hydralazine and guanethidine were continued, as noted in Table II, in those patients who had been taking them for two months or more prior to the study; the dose was not changed during the investigation. Patients remained ignorant of the nature of the experimental medication throughout the study, although physicians had a strong and correct suspicion of the identity of medications A and B.

Results were analyzed by methods applicable to small samples and Students t Test applied. In the results that follow, the term "statistically significant difference" is applied to those data for which the probability of identity is less than one chance in 20 ($P < 0.05$).

Results

The results are tabulated in Table II and summarized in Table III. The patient population studied is representative of that attending the Cardio-renal and Hypertension Clinics at Detroit Receiving Hos-

Doctor Ramos is Renal Fellow, Wayne State University College of Medicine and Detroit Receiving Hospital. His present address is Metropolitan Hospital, Detroit, Michigan.

Doctor Retan is Assistant Professor of Medicine, Wayne State University College of Medicine; Director, Renal Service. Detroit Receiving Hospital.

pital. Their therapy, as well, was conventional for those clinics.

During the course of the trial with the two thiazide-Rauwolfia compounds, significant changes in blood pressure occurred in both groups. The average decrease in systolic pressure was about 18 ml. of mercury; in diastolic, about 12. Nine of the 23 patients attained a diastolic pressure of 90 or less by the end of the study while only one had a diastolic at this level when the combined agents were started. The probability that this change occurred by chance alone is less than one in 1000.

In the comparison between the two agents, Table III indicates that in the sequence ABBA reinstitution of compound A at the start of the fourth week appeared to cause a significantly greater decrease in systolic and diastolic pressures than did reinstitution of compound B in sequence BAAB. However, when the *total* change produced by compound A in the first and fourth weeks in the ABBA group is compared with that produced by compound B in the BAAB sequence no statistically significant differences are apparent.

Changes in serum sodium and potassium during the course of the study were most unimpressive. No significant differences occurred in either during treatment with either compound despite the presence of potassium in compound A.

The blood urea nitrogen showed a minor and statistically significant rise in the first week of treatment in both groups and then began a gradual decline to below basel levels which barely reached a level of statistical significance. There was no difference between the compounds tested in this effect.

The serum uric acid showed minor fluctuations under the influence of both compounds, tending to rise slightly under the course of treatment. The elevation is probably significant.

There was no significant difference in the incidence of side effects during treatment with either compound.

TABLE I. SMITHWICK CRITERIA FOR DIVIDING HYPERTENSIVE PATIENTS INTO FOUR GROUPS*

Group	Numerical Grade	Other Criteria
1	Less than 4	Eyegrounds grade 0 or 1. No changes in cerebral, cardiac or renal areas.
2	Less than 4	Eyegrounds grade 0 or 1 with changes in cerebral, cardiac and/or renal areas. Eyegrounds grade 2, 3 or 4 with or without changes in cerebral, cardiac or renal areas.
3	4 or more	Resting diastolic level below 140 m.m. Changes are present in cerebral, cardiac and/or renal areas but they do not include the following: (a.) C.V.A. with marked residual (b.) Frank congestive failure (c.) P.S.P. below 15 per cent in 15 minutes associated with a poor response to sedation.
4	4 or more	Resting diastolic blood pressure below 140 m.m. combined with one or more of the following: (a.) C.V.A. with marked residual (b.) Frank congestive failure (c.) P.S.P. below 15 per cent in 15 minutes combined with a poor response to sedation. Patients with a resting diastolic level of 140 m.m. or more.

*Smithwick, Reginald H.: *Surgical Measures in Hypertension*, p. 49. Springfield, Illinois: Charles C. Thomas, 1951.

Discussion

The antihypertensive properties of the thiazide and Rauwolfia derivatives are so well known as to require little comment.[1,2]

For the former compound, the mechanism of action is uncertain. A number of authors have postulated decreases in plasma volumes secondary to hyponatremia either as an explanation of the usual depressor effect or of the synergism seen between thiazides and ganglionic blocking agents[3-6] but measurements of plasma volume, extracellular fluid volume, and exchangeable sodium[7] have not supported this hypothesis. Lauwers and Conway have postulated intracellular dehydration affecting arteriolar walls and have also drawn attention to Perera's work[8] indicating the hypotensive effects of potassium deficiency. All of these may prove to be an inadequate explanation in view of a report of an antihypertensive thiazide without diuretic properties.[9]

The antihypertensive potency of Rauwolfia derivatives is less striking[10,11] although they may be effective synergists with stronger agents.[12] They are believed to act by affecting storage and metabolism of serotonin and cathechol amines and, despite a significant incidence of side effects,[10,11] have frequently been used in combination with thiazides[13,14] as well as with other agents.

The results of thiazide therapy alone or in combinations with Rauwolfia compounds in previously untreated patients have usually been of the same order of magnitude as those reported here,[15-19] both in the reduction of systolic and diastolic blood pressure and in the effect of serum uric acid and potassium.[20-23] Hypokalemia is usually described as not a very serious side effect[6] although it may lead to digitalis toxicity[16] and to anatomic and functional renal impairment.[17,24] It was disappointing that the combination of Cyclothiazide and Sandril with 500 mg. of potassium chloride used in this study did not over-ride the hypokalemic tendency.

The observation that statistically significant decreases in systolic and diastolic blood pressures occurred in

TABLE II.

Pt.	Age	Sex	Race	Class	Pre-Study Therapy		Pre-Study BP	Pre-Study BUN	Pre-Study NA	Pre-Study K	Pre-Study Uric	Week No. 1 BP	Week No. 1 BUN	Week No. 1 NA	Week No. 1 K	Week No. 1 Uric	Week No. 2 BP	Week No. 2 BUN	Week No. 2 NA	Week No. 2 K	Week No. 2 Uric
ABBA's																					
JF	62	F	N	I	H 100, R 0.50		160/100	21	144	3.4	8.1	160/100	21	140	3.1	9.8	157/98	23	140	2.8	9.0
JL	53	M	N	III	H 50, R 0.75 A 100		187/93	42	140	5.6	7.9	187/90	40	148	4.6	10.3	197/100	40	151	4.1	9.1
EP	53	F	N	II	R 0.75		187/110	20	140	3.7	3.2	167/107	31	147	4.7	7.8	178/100	—	132	4.4	5.0
WS	69	F	N	III	H 50	a	177/110	18	144	4.1	4.2	157/93	31	140	3.6	12.6	153/93	21	148	3.5	7.0
WL	55	M	N	III	H 100, R 0.50	a	177/97	46	147	4.3	8.5	183/90	40	137	3.6	11.2	197/100	40	148	3.8	10.3
LQ	63	M	W	II	H 100	b	203/103	22	144	4.2	5.3	177/99	25	132	3.4	7.7	173/100	22	148	4.5	5.9
ES	51	F	N	II	H 100, R 0.25, A 100		167/110	26	147	3.4	7.7	157/100	28	154	2.7	12.0	157/100	22	144	3.4	11.4
GB	58	M	N	III	H 50, R 0.50, A 75		147/100	33	147	2.8	—	157/117	32	151	3.5	9.0	153/103	37	144	3.6	9.6
WH	62	M	N	III	H 50, R 0.50		183/110	27	140	3.1	10.3	173/107	25	148	4.1	11.2	163/110	23	140	4.7	9.6
AJ	62	M	N	III	R 0.50, A 100		187/117	—	137	4.4	6.7	173/120	32	140	4.3	6.7	167/107	24	144	3.7	8.3
GT	37	F	N	I	R 0.75	c	143/100	—	—	—	—	146/103	28	135	4.1	4.5	142/97	19	144	3.4	5.3
LR	52	F	N	III	H 100, R 0.50		173/97	—	144	5.7	—	167/90	29	151	4.7	7.4	157/83	38	151	3.9	8.1
BAAB																					
IR	62	F	W	II	None		180/110	21	140	4.9	4.5	157/93	22	144	3.0	3.8	167/93	24	134	4.0	3.3
KC	55	F	N	III	H 100, R 0.50, A 150		178/130	16	144	3.1	7.4	170/120	11	151	3.4	9.1	176/100	13	147	3.7	8.1
LP	60	F	N	III	H 50	a	176/110	23	137	3.5	6.6	170/103	33	144	3.2	7.8	167/94	—	137	3.7	7.1
VA	50	F	N	III	H 50, R 0.50		187/134	90	140	4.9	7.6	157/123	121	129	3.6	10.5	160/120	—	134	3.3	10.4
LL	53	F	W	I	H 100	b	150/100	12	149	3.6	3.7	147/97	18	144	3.4	5.7	153/90	19	132	4.1	5.7
AR	46	M	N	IV	R 0.50, A 200	d	257/130	31	140	3.8	5.8	220/117	52	130	2.7	10.3	220/137	40	148	3.5	8.1
LPR	37	M	N	III	H 100 A 100	a	169/100	78	140	4.2	9.8	160/100	51	140	3.8	7.4	163/94	64	132	3.6	10.4
MR	73	F	N	II	None		187/90	25	151	4.0	5.7	170/87	23	148	4.0	7.7	173/90	13	140	3.3	6.7
ESI	64	F	N	III	H 50	a	177/103	24	149	4.0	6.6	150/100	26	140	5.1	8.2	153/100	15	140	4.7	7.3
HS	56	M	N	II	H 50, R 0.25		143/97	30	147	3.2	7.8	147/97	25	137	3.9	8.0	140/97	14	140	5.1	6.5
AW	67	M	N	III	R 0.50	c	183/110	32	144	3.5	8.2	173/93	22	140	3.6	7.3	177/110	18	144	3.3	6.8

a—Digitalis leaf 100 mg. or its equivalent as Digitoxin.
b—Rauwolfia Serpentina 200 mg.
c—Trichlormethiazide 8 mg.
d—Guanethidine 50 mg.

H—Hydrochlorothiazide
R—Reserpine
A—Hydralazine

TABLE II. (Continued)

Pt.	Age	Sex	Race	Class	Pre-Study Therapy		Week No. 3 BP	BUN	NA	K	Uric	Week No. 4 BP	BUN	NA	K	Uric	Remarks
ABBA's																	
JF	62	F	N	I	H 100, R 0.50		150/87	17	151	3.5	9.0	147/87	21	151	3.4	7.9	—
JL	53	M	N	III	H 50, R 0.75, A 100		210/97	32	147	4.7	9.6	183/90	33	147	5.2	8.1	—
EP	53	F	N	II	R 0.75		167/100	22	140	5.0	3.6	153/90	18	144	4.2	4.7	Nausea—first week only
WS	69	F	N	III	H 50	a	157/93	13	140	4.6	6.4	157/90	16	147	3.3	5.9	Continued on digitalis
WL	55	M	N	III	H 100, R 0.50	a	190/87	48	151	4.2	10.4	180/90	44	140	4.7	9.6	Continued on digitalis
LQ	63	M	W	II	H 100	b	177/100	22	151	5.1	6.2	170/100	20	144	5.1	7.1	—
ES	51	F	N	II	H 100, R 0.25, A 100		153/93	18	140	3.8	11.2	147/90	14	140	4.3	10.3	—
GB	58	M	N	III	H 50, R 0.50, A 75		153/100	31	148	3.7	9.4	147/100	32	151	4.3	8.5	—
WH	62	M	N	III	H 50, R 0.50		167/100	21	152	3.6	10.3	163/100	21	140	3.7	9.5	—
AJ	62	M	N	III	R 0.50, A 100		170/107	24	147	6.6	8.5	167/100	23	140	4.3	7.0	—
GT	37	F	N	I	R 0.75	c	150/100	21	147	7.0	5.2	133/100	14	149	4.0	4.5	—
LR	52	F	N	III	H 100, R 0.50		160/90	26	147	4.3	8.1	143/87	30	149	4.2	6.3	—
BAAB																	
IR	62	F	W	II	None		157/97	19	140	3.9	4.1	157/93	16	129	3.3	4.0	—
KC	55	F	N	III	H 100, R 0.50, A 150		154/100	14	140	8.8	8.0	154/100	10	149	5.0	8.2	—
LP	60	F	N	III	H 50	a	147/87	22	140	3.4	7.2	147/90	21	140	3.4	8.4	Digitalis discontinued after 2nd wk. due to nausea, weakness & bradycardia
VA	50	F	N	III	H 50, R 0.50		157/120	133	135	4.1	12.4	153/103	110	144	3.8	10.3	Nausea & vomiting during 1st wk only
LL	53	F	W	I	H 100	b	143/97	7	147	6.6	4.7	140/90	4	134	2.9	4.1	—
AR	46	M	N	IV	R 0.50, A 200	d	217/130	27	147	4.2	7.0	200/123	42	147	3.7	7.9	Continued on hydralazine & guanethidine
LPR	37	M	N	III	H 100 A 100	a	167/90	60	148	3.5	7.9	163/87	61	140	4.9	7.8	Weakness 1st wk only; continued on hydralazine & digitalis
MR	73	F	N	II	None		173/90	18	144	3.8	5.3	173/90	17	147	4.3	7.1	—
ESI	64	F	N	III	H 50	a	137/80	13	140	4.1	7.4	147/93	15	147	4.8	7.1	Continued on digitalis
HS	56	M	N	II	H 50, R 0.25		140/97	18	152	4.3	6.5	140/90	23	137	4.3	6.5	—
AW	67	M	N	III	R 0.50	c	177/100	23	143	3.7	5.9	173/97	17	140	6.8	6.2	—

a—Digitalis leaf 100 mg. or its equivalent as Digitoxin
b—Rauwolfia Serpentina 200 mg.
c—Trichlormethiazide 8 mg.
d—Guanethidine 50 mg.

H—Hydrochlorothiazide
R—Reserpine
A—Hydralazine

TABLE III. SUMMARY OF CHANGES IN BLOOD PRESSURE AND IN SERUM SODIUM, POTASSIUM, UREA NITROGEN AND URIC ACID

		Week 1		Week 2		Week 3		Week 4		Total Change	
		Syst.	Diast.	Syst.	Diast.	Syst.	Diast.	Syst.	Diast.	Syst.	Diast.
Blood Pressure											
ABBA	Mean change	− 7.25	−2.58	−0.92	− 2.08	+0.83	−3.08	−9.5	−2.5	−16.75	−10.75
	S.D.	11.34	8.29	7.95	7.75	6.91	6.04	7.83	3.79	12.33	7.23
	P	0.05	0.3	0.8	0.4	0.7	0.1	0.001	0.05	0.001	0.001
BAAB	Mean change	−14.6	−7.64	+2.55	− 1.36	−7.27	−2.09	−2.0	−2.91	−21.82	−14.0
	S.D.	13.1	9.89	4.59	10.07	8.56	7.63	6.34	7.46	15.67	11.79
	P	0.01	0.05	0.1	0.7	0.02	0.4	0.3	0.2	0.001	0.001
Between sequences	P	0.2	0.2	0.2	0.8	0.02	0.7	0.02	0.9	0.4	0.5
Serum sodium											
ABBA	Mean change	+1.27		+0.92		−2.25		−1.58		+1.73	
	S.D.	7.47		9.41		6.27		6.07		4.88	
	P	0.6		0.7		0.2		0.4		0.3	
BAAB	Mean change	−3.09		−1.73		+4.36		−2.00		−1.00	
	S.D.	6.79		8.82		7.29		8.74		9.09	
	P	0.2		0.5		0.1		0.5		0.7	
Serum potassium											
ABBA	Mean change	−0.22		−0.05		+0.38		0.00		+0.22	
	S.D.	0.77		0.60		0.58		0.63		0.81	
	P	0.3		0.8		0.8		1.00		0.4	
BAAB	Mean change	−0.27		+0.24		+0.05		+0.15		+0.19	
	S.D.	0.85		0.65		0.57		0.68		1.07	
	P	0.3		0.2		0.9		0.6		0.6	
Urea nitrogen											
ABBA	Mean change	+2.00		−2.00		−3.27		−0.75		−4.00	
	S.D.	6.25		6.00		5.60		3.55		4.09	
	P	0.4		0.3		0.1		0.5		0.02	
BAAB	Mean change	+2.00		−3.33		−2.33		−1.64		−7.01	
	S.D.	15.43		8.52		6.86		9.09		7.95	
	P	0.7		0.3		0.4		0.6		0.05	
Between sequences	P									0.3	
Uric acid											
ABBA	Mean change	+2.4		−0.56		+0.06		−0.83		+0.86	
	S.D.	1.56		1.35		0.34		0.63		1.12	
	P	0.005		0.2		0.6		0.001		0.05	
BAAB	Mean change	+1.1		−0.49		−0.36		+0.11		+0.35	
	S.D.	1.93		4.15		1.2		1.02		1.63	
	P	0.05		0.7		0.4		0.7		0.5	

our previously treated group was both surprising and gratifying. There is little question that the degree is sufficient to improve the prognosis in several of these patients.[25] There are three possible reasons why it occurred.

First, it is possible that the increased attention paid during the study produced profound placebo effect. We deliberately chose "old timers" to the clinics to minimize this likelihood and our results exceed the usual response produced by placebos.[10,11]

Secondly, it may have been that the treatment previously prescribed had been inadequate. If this had been so, patients showing the greatest drop in blood pressure should have been those receiving less than optimal doses of antihypertensive drugs before treatment was begun. Reference to Table II does not suggest that this was so.

Our third alternative is that the patients had been taking less medicine than had been prescribed. To test this hypothesis, patients whose blood pressures responded during this study were contacted and questioned about their prestudy therapy. Most indicated that irregularity in taking their medications had occurred either because of failure to prescribe enough to last from one clinic visit to another or because of failure of the Pharmacy to furnish the full number of pills prescribed. Two patients admitted to some forgetfullness.

Conclusion

We infer from this study of a small group of previously uncontrolled hypertensive patients that an adequate degree of control can be obtained with some of the milder hypertensive agents, without prohibitive disturbances of the blood urea nitrogen, potassium, and uric acid, provided that measures are taken to insure that the medicines prescribed are taken in full therapeutic doses on a regular basis. There is no perceptible difference between the two compounds tested in their capacity to bring about this favorable response.

Acknowledgment

We are deeply indebted to the Eli Lilly Company for a grant to support this study and to Ciba Pharmaceuticals for the supply of medications used.

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(References are on Page 582)

Congenital Entropion of the Upper Eyelids

David Barsky, M.D.
Wyandotte, Michigan

SEVERE congenital anomalies of the eyelids are fortunately rare.[1,2,3] Entropion becomes a problem when the eyelashes turn inwards, abrade and finally erode the corneal epithelium. The newborn has rather limited means of communication, so that prolonged trichiasis can result in serious corneal damage, without being recognized. The significance is illustrated in the following report.

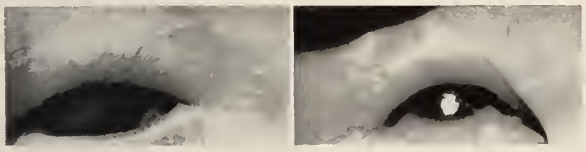


Fig. 1. Left eye: Dense corneal opacification due to trichiasis.

Fig. 2. Right eye: Upper eyelid margin and eyelashes hidden by marked entropion.

Case Report*

A 3½-month-old white male infant was first seen in our office on May 4, 1960. The mother presented the baby with the complaint that she "had not seen the baby's eyes since birth." The baby was a full-term infant, and the delivery and development post-natally were normal, aside from the fact that the baby had "never opened its eyes." The mother apparently had been content to wait for the child to open its eyelids spontaneously, and had not forced the lids open to examine the eyes. She became concerned when a discharge began to collect at the medial canthus each morning.

On examination, the baby's eyes were tightly closed. A mucoid discharge was pooled at the medial canthus. The eyelid margins and eyelashes were hidden by the skin of the eyelids as the lids appeared to be in a state of marked spasm. After immobilizing the baby in a blanket, traction was exerted on the upper eyelid, thus visualizing the lower eyelid margin and inferior limbus. The upper eyelids were rolled inwards tightly with the eyelashes abrading the cornea, inducing a dense corneal haze centrally.

In the left eye the corneal opacity was a 5 to 6 mm. ellipse (Fig. 1). while the right eye was affected to a lesser extent (Fig. 2). The anterior chambers were formed, and the pupils were round and regular. Aside from the eyelids and cornea, the ocular structures appeared grossly normal. The initial impression was: (1) congenital entropion of the upper eyelids; (2) corneal ulceration, bilateral, secondary to trichiasis.



Fig. 3. Postoperative result (June 1960). Eyelashes in normal position.

Clinically, the spasm of the orbicularis muscle was a *striking* feature. The tarsal plate appeared normal. Because of the gross corneal damage, it was felt that surgery offered the most immediate and effective treatment.

Under (light) ether anesthesia, the left eye was prepared and draped. A deep lateral canthotomy was performed with the Steven's scissors for a distance of *4 to 6 mm.* Almost immediately the orbicularis muscular spasm relieved, but the trichiasis persisted. Two 6-0 double armed black silk sutures were inserted subcutaneously at the level of the upper border of the tarsal plate, and the suture was brought out on the grey line of the lid margin. By exerting traction on these sutures, the upper eyelid was everted, turning the eyelashes upwards and outward, while exposing the cornea. To maintain the eversion of the upper lid, the sutures were taped to the forehead for continuous traction.

A similar procedure was then performed on the right eye.

Postoperatively, Chloramphenicol (0.5 per cent) ophthalmic solution, one drop every hour, was instilled in each eye during the day, and Neosporin® ophthalmic ointment was instilled at night. The cornea healed well, and by the sixth

*Wyandotte General Hospital Case No. 264626.

Photography through the courtesy of Mr. A. Bowden, Detroit, Michigan.

postoperative day, all the sutures were removed. The upper lids remained in normal position with good closure, and no evidence of trichiasis.

The patient was discharged on the sixteenth postoperative day, at which time, the right cornea was quite clear, though the stroma was still opaque in the left eye. Antibiotic therapy was maintained at home.

The baby was seen in our office for follow-up care. By June 1960, the only residual defect was a slight stromal haze in the left cornea. Both lids functioned well and the eyelashes were in normal position (Fig. 3).

Discussion

The etiology of primary entropion is probably varied.[4,5,6] Duke-Elder notes several reports which identify "hypertrophy of the marginal portion of the orbicularis muscle" as the factor in spastic entropion.[7,8] The case herein presented substantiates this thesis. The fact that a deep lateral canthotomy was successful, seems to indicate a localized anomaly.

Summary

A case report of bilateral congenital entropion of the upper eyelids, with trichiasis and corneal damage is presented. Spasm of the marginal portion of the orbicularis muscle appeared to be the main defect. Deep lateral canthotomy along with traction-eversion of the upper eyelids corrected the anomaly with no apparent residual corneal damage.

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(Continued from Page 580)

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The Fall and Rise of Lumbar Sympathectomy In Arteriosclerosis Obliterans

Jere W. Lord, Jr., M.D.
New York, New York

EVOLUTION of the surgical treatment of intermittent claudication due to atherosclerotic disease of the femoro-popliteal artery has matured a good deal in recent years.

In the decade of the 1940s, lumbar sympathectomy was reserved for the most part for the treatment of ischemic lesions of the foot. Silbert[1] and Elkin[2] independently demonstrated that abolishment of sympathetic tonus failed to augment blood flow to the calf musculature, the trigger zone for the production of intermittent claudication.

In the decade of the 1950s, the arteriographic demonstration that atherosclerotic lesions were often segmental led many surgeons in France,[3] in England[4] and in the United States[5,6] to evolve techniques to overcome by direct means the effects of the obstructed arterial segment employing endarterectomy,[7] excision and replacement[8] and by-passing with autologous venous grafts,[5] homologous arterial grafts,[9] nylon,[10] dacron[6] and teflon prostheses.[11] Recently, endarterectomy has been combined with a long roof patch of autologous venous graft.[12] Early results of the direct surgical techniques were exciting and glowingly reported. Sadly, however, as the decade of the 1960s approached, carefully followed series of patients were reported which revealed a most distressing attrition rate of patency of these surgical tours de force. Some of us[13,14] who were aware of the serious limitations of direct surgical intervention found solace in the fact that large series[15] were reported with a similar pattern.

About this time, laboratory investigation by several workers showed that the greatest stimulus to the development of collateral arterial circulation was the differential in pressure between the patent artery above the occluded segment and the patent artery below the zone of occlusion. The accumulation of metabolites in the exercised muscle was of secondary importance as were changes in oxygen tension and pH. One careful experimental study[16] revealed that the elimination of the pressure differential by a by-pass graft led to regression of the collateral circulation to the pre-occluded level. Further, that the by-pass sometimes caused occlusion in the main arterial segments near the by-pass which could lessen the effectiveness of the collateral circulation when the by-pass closed. In other words, eventual failure of the by-pass graft could in some patients lead to a circulatory state worse than that of their pre-by-pass status.[17]

Although Atlas[18] suggested that lumbar sympathectomy was capable of augmenting the collateral arterial circulation, it required further studies by de Takats[19] and Edwards[20] to bring convincing evidence that that operation will directly and progressively effect improvement in the arterial flow to the deep musculature in addition to the generally accepted effect of sympathectomy on the blood flow to the skin. There is progressive improvement over a long period in the majority of patients.

Lumbar sympathectomy should be thorough and extensive (ganglia L1 through L4 by removing the chain from the diaphragm to the common iliac artery). It has a low operative mortality, but many patients have a moderate degree of morbidity—post-sympathectomy pain in the lower abdomen and thigh, worse at night and persisting for several weeks to several months. Sympatholytic and sympathomimetic drugs have been of little help. Thiamine chloride in large doses (100 mg. daily) may help, and drugs such as darvon and aspirin have usually been sufficient to control discomfort. Spontaneous clearance of the pain has taken place in due time.

Recently, a beautifully conducted objective study of patients' claudication distance before and after lumbar sympathectomy by Mackenzie and Loewenthal[21] demonstrated that at least 50 per cent of patients have significant improvement in walking distance. The report was in the preliminary stage and based on my own observation, more of their patients will show further improvement as the post-operative period lengthens.

From the Department of Surgery, New York University Postgraduate Medical School.

Presented at the annual meeting of the Michigan State Medical Society, Detroit, September 27, 1962.

Between January 1956 and December 1960, 16 private patients underwent lumbar sympathectomies for intermittent claudication due to femoro-popliteal occlusion on an atherosclerotic basis. There were no hospital deaths, and one patient died nine months postoperatively from bronchogenic carcinoma. Preoperative walking distance increased from an average of slightly under one block to an average of five blocks; in three patients, walking was unlimited. All pedal pulses were absent before operation and were detected in 10 of 16 patients postoperatively. Oscillometric testing at the calf level rose from a pre-operative average of 0.3 units to 1.1 units postoperatively. Patients had been urged to discontinue tobacco preoperatively, and eight of sixteen had not smoked for varying periods pre-operatively. In the postoperative period, four more gave up smoking.

The favorable results just cited may be compared and contrasted with the results of lumbar sympathectomy in patients with femoro-popliteal occlusion wherein there is also rest pain with either ulceration or gangrene. During the same period, 28 patients were operated upon. Although there were no hospital deaths, eight have subsequently expired from two months to four years. Four of the 28 limbs had to be amputated. Of 17 patients who experienced significant improvement, 16 are living and one died after four years from a coronary occlusion.

It is my present policy to perform on all patients with femoro-popliteal occlusion, in whom intermittent claudication is a disabling factor, a percutaneous femoral arteriogram. This is done in the operating room under general anesthesia. If there is a short (1-5 cm.) segmental block in the femoral artery in the adductor canal or proximal to that area, and if the proximal femoral artery and the distal popliteal artery are excellent, smooth-walled vessels, then an endarterectomy or autologous vein graft by-pass is done. If the arteriogram is less favorable, then an immediate lumbar sympathectomy is carried out.

In summary, the disappointing long-term results of direct arterial surgery in the vast majority of carefully followed patients has led me to rely on extensive lumbar sympathectomy as the best way to treat patients with significantly troublesome intermittent claudication due to femoro-popliteal atherosclerotic occlusive disease. Results are gratifying in 75 per cent of patients. The physiological principles lending support to this approach have been discussed.

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Vaccination in Children with Eczema

Alex F. Robertson, M.D.
Ann Arbor, Michigan

VACCINATION of children against smallpox is the public health duty of every physician. It is an elective precedure and, as such, need not be done when it constitutes any danger to the patient. The physician in his office and with his knowledge of the family is better situated to evaluate the safety of vaccination than most public clinics. Since 1953, we have seen a total of seven cases of eczema vaccinatum in the University of Michigan Pediatric and Communicable Diseases Department. In six of these cases, the vaccination was performed in the doctor's office and not at a clinic. Two cases are presented briefly to emphasize the importance of a careful history before vaccinating a child.

Case Reports

Case 1.—This 2½-year-old girl developed eczema at three months of age. At no time had it cleared completely and as recently as six months prior to admission, she began an elimination diet to control her eczema. Seven days before admission, in the presence of obvious eczematous lesions, she was vaccinated for the first time. Six days later, vesicles appeared at the site of vaccination and within 24 hours, umbilicated lesions presented in many areas of her body. On admission, lesions were present on both shoulders, suprascapular areas, posterior chest, right lower quadrant of the abdomen, inguinal regions, both anterior thighs and lower legs. A chronic eczematous rash covered her face, antecubital and popliteal areas. The child received topical therapy and 8.5 milliliters of vaccinia hyperimmune globulin. During the first four days of hospitalization, her temperature rose daily to over 104 degrees F. (rectally). Afterwards, her temperature gradually subsided and she was discharged on the 14th hospital day.

Case 2.—This 2-year-old boy had eczema since the first month of life. Twenty days before admission, his older sister was successfully vaccinated. Three days before admission, the patient developed a fever and persistent vomiting, followed in 24 hours by vesicular lesions on the face. On admission, the entire face was covered with umbilicated lesions and the left eye was swollen shut. Lesions were spread diffusely over the remainder of his body. He received topical treatment and 10 milliliters of vaccinia hyperimmune globulin. His fever persisted for four days and he was discharged on the 13th hospital day.

From the Department of Pediatrics and Communicable Diseases, University of Michigan Medical Center.

Discussion

In these cases, vaccination of a child with active eczema has occurred only one time (Case 1). In another case, a four-month-old boy whose eczema was temporarily clear was vaccinated and four days later the eczema recurred. Obviously, the vaccination was contraindicated in view of the past history, since we know that exacerbations of eczema are frequent in this age group. Four other cases involve the vaccination of a sibling or close associate. A 10-month-old boy, residing in a foster home developed eczema vaccinatum after another child in the house was vaccinated. In this group of patients, one death occurred. Ironically, in the fatal case, a 10-month-old girl had three siblings vaccinated simultaneously. She died following the perforation of a pyloric ulcer occurring about the seventh day of her illness. In another family, the sibling of a child with eczema was vaccinated without apparent spread to the patient with eczema. One week later, the father developed several umbilicated lesions on his lips and two weeks thereafter, eczema vaccinatum developed in the unvaccinated child.

Before vaccination (or revaccination) of any child, it should be determined that no member of the family has any "skin trouble" which resembles eczema. Many people are unfamiliar with the term, "eczema," and the simple question, "Has anyone in the family got eczema?" is, therefore, not sufficient. Any child with active eczema should not, of course, be vaccinated. What should be done with a child whose eczema has cleared? If the physician feels that vaccination must be carried out, a safe procedure is to vaccinate only those children who are over five years of age and have not had an exacerbation of eczema for at least one year. If the eczema persists or if the physician is concerned about the possibility of this complication, he should not feel that vaccination is mandatory. For

admission to public school, it is sufficient for the child to have a statement from the doctor saying the vaccination is contraindicated. For travel abroad there is no absolute assurance derived from a doctor's statement. Vaccination is not required under six months of age. For entering other countries from this country, it is usually sufficient for a child to have a doctor's statement concerning the inadvisability of vaccination. If, however, he comes from an area where there has recently been reported a case of smallpox, he may be placed under strict surveillance or even quarantined. Since these rules are subject to personal interpretation by immigration officials, the doctor cannot assure the parents that his letter will suffice. In most cases, it probably will.

Aside from describing the general course of the response to the vaccination, the parents should be warned that the child with an active vaccinia lesion is a danger to any of his associates with "skin trouble."

In the unfortunate instance when the sibling of an eczema patient is vaccinated, the two should be separated until the vaccination has healed or until it is clear that the vaccination is ineffective. In some circumstances, this may be accomplished in the home but ideally, one child should be sent to stay with a friend or relative. If intimate exposure occurs, or if a child with eczema is vaccinated, vaccinia hyperimmune globulin may be used. However, it is not known that this will afford complete protection.

These cases emphasize the danger of vaccination in families with an eczematous child. The family physician is ideally knowledgeable of the necessary history which should be taken before vaccination. There is no reason for him to feel "pushed" into vaccination where it is contraindicated, for in most circumstances, his written statement will suffice to allow an exception to the rules. The incidence of eczema vaccinatum is low as judged by the number of cases seen in this hospital in the last 10 years. In each case, however, simple precautions would have averted this serious illness.

Respiratory Disease Rising Fast as Disabler

Chronic lung disease is the fastest rising cause of total disability in the United States today, according to Dr. Richard W. Stone, New York City.

Social Security data indicate that worker disability allowances for chronic lung disease are surpassed in number only by those for heart disease due to hardening of the arteries, he said in an article in the January *Archives of Environmental Health*, published by the American Medical Association.

In men, Dr. Stone said, lung cancer and chronic respiratory disease, which includes bronchitis, pneumonia and emphysema, are rising at "an alarming rate." In 1950, he said, the combined death rate of these diseases in men was 23.5 deaths per 100,000, whereas, in 1959, it had risen to 44 deaths per 100,000.

Up to the age of 40, men and women have about the same number of deaths and these are of low incidence, he said. By age 50, three times the number of men die from chronic respiratory diseases as do women, and by age 60 the difference is of the order of 7 times greater for men, he said. In men, there has been a 100-fold increase between ages 35 and 65, whereas, in women, the increase has been only 10-fold, he said.

Hospital Abuse --- The Tiresome Theme

By Lawrence A. Hill
Associate Professor of Hospital Administration and
Director of the Program and Bureau of
Hospital Administration,
University of Michigan

I know a pediatrician and his wife who wished to spend a weekend at a fancy resort in Florida. They were unable to find a babysitter so they admitted their kids to the hospital while they were gone and Blue Cross paid the bill.

Practically everyone has heard this or similar stories. Did it happen? Perhaps. Does it happen with any degree of regularity? No.

* * *

ABUSE OF HOSPITALS caused by physicians needlessly admitting patients and caused by patients demanding admission so that Blue Cross will pay the bill is a theme played tirelessly by critics of hospitals and physicians. Scarcely anyone to whom you talk has ever done this himself, you understand, but he knows several others who have. Has a physician ever admitted a patient who did not need hospital services? Has a patient demanded admission, and received it, so Blue Cross would pay the bill? Certainly; why deny it? But no one has ever produced evidence that this is a common practice. Like many other accusations, this one has a trace of truth in it and therefore gains credence especially when emotionally espoused.

Perhaps the most careful examination of the appropriateness of hospital use yet carried out is a portion of The University of Michigan's Study of *Hospital and Medical Economics*, entitled "Character and Effectiveness of Hospital Use." This study inquired into the use of hospitals in Michigan during the year 1958. Eighteen of the most prevalent diagnoses in the hospitalized population of that year were selected for study. Criteria for admission, treatment and discharge were established by panels of boarded specialists. A sample of 1958 cases was measured against these criteria and judgments were drawn concerning the appropriateness of the patient's length of stay and of his admission. The results of this study showed that in less than three per cent of the cases could the admission be questioned as not appropriate. And certainly no claim was

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made that even those judged not appropriate were caused by a conscious effort to abuse the hospital.

There is no doubt that hospital utilization is a serious problem in hospital and medical economics. And to the extent that our hospitals are not being wisely used, there is a diseconomy. Further, no knowledgeable person will hold out the illusion that hospitals are being used perfectly and with mathematical precision. There is unquestionably some abuse of hospitals. Most of this is caused by honest error and some of it is undoubtedly caused by persons seeking to beat the system. But to repeat, this is not a common practice and indeed is extremely rare.

* * *

IF SOME ABUSE DOES exist, however, it is up to those responsible to do what they can to eradicate it. This means careful studies, hospital by hospital, of utilization. This means self-discipline on the part of the hospital medical staffs and on the part of hospital administration. This means a serious attempt to measure and quantify utilization so that the abuse of hospitals or the lack of abuse can be isolated, measured and reported for all to see. The vast majority of hospitals and medical staffs have nothing to hide. They should be eager to study and measure their performance and to report it. Once they do, the critics will have a far more difficult task. It is one thing to levy a barrage of criticism when you are certain your target cannot fire back; it is quite another thing when the target is armed to the teeth.

Thanks for Your Assistance

Many fine comments have been heard about the excellent collection of articles by the MSMS Geriatrics Committee in the May JOURNAL. A special "thank you" for obtaining the material is extended to Jack Rom, M.D., Detroit, a member of the Geriatrics Committee.

Facing Mental Health Challenges

By Mrs. W. S. Wille, Jackson,
Mental Health Chairman,
Woman's Auxiliary to MSMS

What can Michigan doctors of medicine and their wives do to help solve mental health challenges?

We should center our activities on the encouraging of high school students to investigate the mental health careers—psychiatry, psychology, psychiatric nursing, social work, special education, recreation therapy, occupational therapy. This might be done through local mental health career programs in connection with, or separate from, high school career meetings. Class trips to clinics or hospitals could be sponsored by the Auxiliary. Future Nurses Clubs should have information on the mental health disciplines.

Another possibility is cooperation with such groups as the AAUW or churches in sponsorship of education programs about mental health. There are a number of films available and both the State Department of Mental Health and the Michigan Society for Mental Health have a wealth of usable material.

Over and above public education and recruitment programs, we can give volunteer services to patients and ex-patients either at state hospitals or in the community hospitals with psychiatric service.

We can also continue to collect sample drugs to be sent for use in any of the state hospitals. The State Department of Mental Health, Program Plans and Budget Request Policy for 1963-64 states: "In medical and health services, the Department is acutely aware that for the past few years the amount of funds that have been available for drug therapies, treatment drugs, specific laboratory and health

services have fallen below the quality of service that is expected of state hospital program."

There also are a number of ways each county society or auxiliary can contribute to the public education program. We can encourage and assist the local school boards to introduce into the curriculum more material on mental hygiene, steps toward maturity and marriage, preparation and understanding of personality development, and requirements for parenthood.

Our leadership with appropriate activities can help meet the needs of the mentally ill and retarded in Michigan and the Nation.

I Seek Opportunity

By Edwin Hamilton, M.D., Past President
Illinois State Medical Society

It is my right to be an uncommon man—if I can. I seek opportunity, not security. I do not wish to be a kept citizen, humbled and dulled by having the state look after me. I want to take the calculated risk, to dream, to build, to succeed and to fail. I refuse to barter incentive for a dole. I prefer the challenges of life to the guaranteed existence, the thrill of fulfillment to the stale calm of Utopia. I will not trade freedom for beneficence, nor my dignity for a handout.

EDITORIAL OPINION

A Medicare Light Dawns

(Detroit Free Press, April 23, 1963)

Three years of opinion sampling, reports Rep. Charles E. Chamberlain of Michigan's Sixth District, shows Medicare to have receded steadily in popularity with the public.

Two years ago, he says, 48 per cent of those heard from favored a Federal medical assistance program to be financed through Social Security taxes paid by employer and employe.

Last year, the percentage in favor dropped to 39, and this year to 27.

We're not at all sure that this drop indicates loss of popularity among those who believe in the necessity for a medical plan so financed and administered —especially the need of its benefits to the elderly who live on small retirement incomes.

More likely, it seems to us, there has been a growth of understanding concerning the measures which the Administration has offered.

Whether the citizen is for or against the principle embodied in what has come to be called Medicare, people are increasingly aware that the actual assistance offered covers only a fraction of the medical care required by victims of sickness or accident—and that the person of limited means would still find himself hard put to meet the bills.

In other words, a light has dawned. People have come to realize that Medicare is a much better political noise than it is a program for helping those who might need help.

This shows a very significant medical trend

* * *

Re Freedoms

(Kalamazoo County Academy of Medicine Bulletin, Vol. 53, No. 4.)

One cannot too frequently reappraise his personal goals and objectives, as well as those of the nation in which he lives. It should again be clear to all of us that each individual must make a physical and mental effort to regain and maintain his individual freedom within the framework of our democracy. We must more than talk about it. We must work at it, actively and physically.

Michigan State Medical Society

Ninety-Eighth Annual Session



O. B. McGillicuddy, M.D.
Lansing
Council Chairman



C. I. Owen, M.D.
Detroit
President



J. J. Lightbody, M.D.
Detroit
Speaker



D. Bruce Wiley, M.D.
Utica
Secretary

OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Grand Rapids, Michigan, September 22-23-24-25-26-27, 1963. The provisions of the Constitution and Bylaws and the Official Program will govern the deliberations.

C. I. Owen, M.D.
President

O. B. McGillicuddy, M.D.
Council Chairman

J. J. Lightbody, M.D.
Speaker

J. W. Rice, M.D.
Vice Speaker

Attest:
D. Bruce Wiley, M.D., *Secretary*



J. W. Rice, M.D.
Jackson
Vice Speaker

THREE-DAY SESSION OF HOUSE OF DELEGATES

September 22-23-24, 1963
First Meeting—Sunday, 8:00 p.m.

The 1963 House of Delegates of the Michigan State Medical Society will hold a three-day session beginning Sunday, September 22, at 8:00 p.m. The business of the House of Delegates will be transacted in the Grand Ballroom of the Pantlind Hotel, Grand Rapids.

The House will meet also on Monday, September 23 at 9:00 a.m. and 8:00 p.m. and on Tuesday, September 24, at 9:00 a.m. and at 8:00 p.m.

SEATING OF DELEGATES

"A Delegate, or in his absence, an Alternate Delegate (in order of seniority) becomes a member of the House of Delegates when duly registered and seated at the Annual Session following his election and certification by the component County Society. Once seated a Delegate shall remain a Delegate throughout the entire Session and thereafter until the next Annual Session of the House of Delegates and his place shall not be taken by any other Delegate or Alternate Delegate except that in case of emergency the House of Delegates may seat a duly accredited Alternate Delegate from the same component County Society. Any Delegate-Elect not present to be seated at the hour of call of the first meeting may be replaced by the accredited Alternate Delegate next on the certified list furnished by his component County Society."—MSMS Bylaws, Chapter 9, Section 4.

Michigan State Medical Society

Ninety-Eighth Annual Session

HOUSE OF DELEGATES
PANTLIND HOTEL, GRAND RAPIDS,
SEPTEMBER 22-23-24, 1963

ORDER OF BUSINESS

SUNDAY, SEPTEMBER 22, 1963

Grand Ballroom, Pantlind Hotel, Grand Rapids

6:00 p.m.—Registration

8:00 p.m.—First Meeting

1. Call to Order by Speaker
2. Report of Committee on Credentials
3. Prayer by Ralph R. Cooper, M.D., Detroit
4. Appointment of Reference Committees:
 - (a) On Constitution and Bylaws
 - (b) On Emergency Medical Service
 - (c) On Executive Session
 - (d) On Hygiene and Public Health
 - (e) On Legislation and Public Relations
 - (f) On Medical Service and Prepayment Insurance
 - (g) On Miscellaneous Business
 - (h) On Reports of Council
 - (i) On Reports of Officers
 - (j) On Reports of Special Committees
 - (k) On Reports of Standing Committees
 - (l) On Resolutions
 - (m) On Rules and Order of Business
 - (n) Special Memberships
 - (o) On Ways and Means
5. Speaker's Remarks—J. J. Lightbody, M.D., Detroit
6. President's Remarks—C. I. Owen, M.D., Detroit
7. President-Elect's Remarks—O. J. Johnson, M.D. Bay City
8. Annual and Supplemental Annual Reports of The Council (including Annual Reports of Committees of The Council)—O. B. McGillicuddy, M.D., Lansing, Chairman of The Council
9. Report of Delegates to American Medical Association—Wm. A. Hyland, M.D., Grand Rapids, Chairman
10. Brief of Annual Report of Woman's Auxiliary—Mrs. R. V. Taylor, Jackson, President
11. Brief of Annual Report of Michigan State Medical Assistants Society—Miss Esther Bartlett, Detroit, President
12. Report of Michigan Medical Service—Sidney Adler, M.D., Detroit, President

MONDAY, SEPTEMBER 23, 1963

Grand Ballroom, Pantlind Hotel, Grand Rapids

9:00 a.m.—Second Meeting

13. Supplemental Report of Committee on Credentials
14. Resolutions
15. Reports of Committees of the House of Delegates:
 - (a) Survey Committee to Study MSMS Financial Structure
 - (b) Standing Committee on Constitution and Bylaws
 - (c) Committee to Study Honorarium for MSMS Officers
 - (d) Committee to Study Relationship Between Doctors of Medicine and Osteopaths
 - (e) Committee to Study Emergency Care in Hospitals
 - (f) Committee on Certificates of Commendation
16. Reports of MSMS Standing Committees
 - (a) Committee on Postgraduate Medical Education
 - (b) Public Health Committee
 - (1) Committee on Cardiac Disease Control
 - (2) Committee on Maternal Health
 - (3) Committee on Venereal Disease Control
 - (4) Committee on Tuberculosis Control
 - (5) Committee on Cancer Control
 - (6) Committee on Occupational Health
 - (7) Committee on Mental Health
 - (8) Committee on Child Welfare
 - (9) Committee on Geriatrics
 - (10) Committee on Rural Medical Service
 - (11) Committee on Blood Banks
 - (12) Committee on Highway Accident Prevention
 - (13) Committee on Diabetes Control
 - (14) Committee on Iodized Salt

(c) Committee on Public Relations
(d) Committee on Ethics
(e) Committee on Legal Affairs
(f) Committee on Mediation
(g) Advisory Committee to the Woman's Auxiliary of the MSMS
(h) Advisory Committee to the Michigan State Medical Assistants Society
(i) Committee on Professional Insurance Plans
(j) Committee of Past Presidents
(k) Medical Socio-Economics Committee
(l) Committee on Scientific Radio and Television

MONDAY, SEPTEMBER 23, 1963

Grand Ballroom, Pantlind Hotel, Grand Rapids

8:00 p.m.—Third Meeting

17. Supplemental Report of Committee on Credentials
18. Unfinished Business
19. New Business
20. Reports of Reference Committees
 (a) On Constitution and Bylaws
 (b) On Emergency Medical Service
 (c) On Executive Session
 (d) On Hygiene and Public Health
 (e) On Legislation and Public Relations
 (f) On Medical Service and Prepayment Insurance
 (g) On Miscellaneous Business
 (h) On Reports of Council
 (i) On Reports of Officers
 (j) On Reports of Special Committees
 (k) On Reports of Standing Committees
 (l) On Resolutions
 (m) On Rules and Order of Business
 (n) On Special Memberships
 (o) On Ways and Means

TUESDAY, SEPTEMBER 24, 1963

Grand Ballroom, Pantlind Hotel, Grand Rapids

9:00 a.m.—Fourth Meeting

21. Supplemental Report of Committee on Credentials
22. Unfinished Business
23. New Business
24. Supplemental Reports of Reference Committees

TUESDAY, SEPTEMBER 24, 1963

Grand Ballroom, Pantlind Hotel, Grand Rapids

8:00 p.m.—Fifth Meeting

25. Supplemental Report of Committee on Credentials

26. GENERAL MEETING OF THE MICHIGAN STATE MEDICAL SOCIETY

Presiding, Clarence I. Owen, M.D., Detroit, President

Installation of New President: Orlen J. Johnson, M.D., Bay City



C. I. Owen, M.D.
Detroit



O. J. Johnson, M.D.
Bay City

27. Awards:
 (a) Report of Committee on "Certificates of Commendation"
 (b) Fifty-Year Awards
 (c) Awards to Employees (per 1961 House of Delegates)

28. Unfinished Business
29. Supplemental Report of The Council
30. Supplemental Reports of Reference Committees
31. Elections
 (a) Councilors:*
 1st District—Warren W. Babcock, M.D., Detroit—Incumbent
 Wyman C. C. Cole, Sr., M.D., Detroit—Incumbent
 2nd District—Oliver B. McGillicuddy, M.D., Lansing—Incumbent
 3rd District—Harvey C. Hansen, M.D., Battle Creek—Incumbent
 4th District—Robert V. Daugharty, M.D., Cadillac—Incumbent

*MSMS Bylaws, Chapter 12, Section 1—Term of Office:

"Except as herein otherwise provided, officers shall take office immediately after the election. With the exception of Councilors, they shall serve until the next Annual Session and until their respective successors shall have been elected. Councilors elected prior to 1960 shall serve for five years. Councilors elected in 1960 and thereafter shall serve for three years, provided, however, that in the year 1963 six Councilors shall be elected for terms of three years each and three Councilors shall be elected for terms of two years each. The election of Councilors in said years shall be conducted in the usual manner as prescribed in Section 10 of Chapter 9 of these Bylaws, and immediately thereafter, the length of the respective terms to be served by those elected shall be determined by lot under the direction of the Speaker of the House of Delegates."

11th District—Wm. M. LeFevre, M.D., Muskegon—Incumbent
12th District—James R. Dehlin, M.D., Gladstone—Incumbent
13th District—D. Roemer Smith, M.D., Iron Mountain—Incumbent
15th District—Robert J. Mason, M.D., Birmingham—Incumbent

(b) Delegates to American Medical Association:
J. R. Heidenreich, M.D., Daggett—Incumbent
W. A. Hyland, M.D., Grand Rapids—Incumbent
O. J. Johnson, M.D., Bay City—Incumbent
L. R. Leader, M.D., Birmingham—Incumbent

(c) Alternate Delegates to American Medical Association:
G. B. Saltonstall, M.D., Charlevoix—Incumbent
J. M. Wellman, M.D., Lansing—Incumbent
Sidney Adler, M.D., Detroit—Incumbent
B. M. Harris, M.D., Ypsilanti—Incumbent

(d) President-Elect
(e) Speaker of the House of Delegates
(f) Vice Speaker of the House of Delegates

32. **Adjournment**

MICHIGAN MEDICAL SERVICE SCHEDULE

Tuesday, September 24, 1963

12:30 p.m.	Preprandial Refreshments, Kent State Room, Pantlind Hotel
1:00 p.m.	Luncheon, Kent State Room, Pantlind Hotel
2:00 p.m.	Meeting of Members of the Corporation, Grand Ballroom, Pantlind Hotel

All MSMS Delegates are members of Michigan Medical Service Corporation and are expected to attend the MMS Luncheon and Annual Meeting. The MMS Annual Meeting is open to ALL members of the medical profession, who are cordially invited to attend.

FORM FOR RESOLUTIONS TO HOUSE OF DELEGATES

All resolutions, special reports, and new business shall be presented in writing in triplicate (Bylaws, Chapter 9, Section 13).

Resolution No.
Subject of Resolution
.....
Introduced by: M.D., of
..... County
Referred to
Whereas, the
.....
Whereas, it is
.....
....., therefore be it
RESOLVED: That
.....

Each Delegate is invited to send copy of all resolutions to Speaker J. J. Lightbody, M.D., Box 152, East Lansing.

MCI Echoes



The public was invited to two MCI panels, including the one on "Why Mental Retardation," led by Jacques S. Gottlieb, M.D., at far right, of Detroit. At the far left is Robert W. Talley, M.D., Detroit, who served as panel secretary. The speakers included Hilda Knobloch, M.D., second from left, Columbus, Ohio; J. A. Churchill, M.D., third from left, Detroit, and John H. Menkes, M.D., fourth from left, of Baltimore. The meeting was made possible through an educational grant-in-aid from Roche Laboratories, Division of Hoffmann-La Roche, Inc., Nutley, N. J.

Upper Peninsula M.D.'s To Meet June 28-29

The 68th annual meeting of the Upper Peninsula of Michigan Medical Society will be held at Sault Ste. Marie on June 28-29. Founded in 1896, this organization meets each year in a different location across the Upper Peninsula.

Eleven speakers have been obtained, and MSMS officials will also participate on the scientific-social program. Speakers and their topics include: R. W. Steenberg, M.D., "Management of the Diabetic Foot"; R. J. Baker, M.D., "Blood Transfusions and Component Therapy"; W. M. Mikkelsen, M.D., "Recent Developments in the Field of Arthritis"; E. M. Berkas, M.D., "Management of Upper Gastrointestinal Hemorrhage by Hypothermia"; R. D. Judge, M.D., "Heart Block"; E. A. Kahn, M.D., "Diagnosis and Management of Brain Tumors"; B. H. Glover, M.D., "Psychiatry for the General Practitioner"; L. A. Lindquist, M.D., "All That Bleeds Is Not Hemorrhoids"; Carl Moyer, M.D., "Recent Advances in the Treatment of Shock"; C. D. Benson, M.D., "Surgical Problems of the Newborn"; and R. L. Rapport, M.D., "Injuries to the Chest."

Claire H. Clausen, M.D., is president of the society, and Earl H. Rhind, M.D., is secretary-treasurer.

Pathology Comment

The Role of the Clinical Laboratory in the Diagnosis of Collagen Diseases

Most physicians at one time or another have been confronted with the problem of making a specific diagnosis when studying a patient with findings suggesting one of the collagen diseases: systemic lupus erythematosis, polyarteritis nodosa, dermatomyositis, scleroderma, thrombotic thrombocytopenic purpura, rheumatoid arthritis, or rheumatic fever. The clinical laboratory, with some exceptions, is of limited value in helping the physician in such a circumstance.

The laboratory findings in the disease systemic lupus erythematosis have excited much interest with the demonstration of the L.E. cell by Hargraves in 1948. This phenomenon has been demonstrated in close to 100 per cent of patients with the disorder in some series. A positive test is more likely to be obtained when the disease is in an acute stage. Experience has shown that it may be wise to repeat the procedure when an initial negative result is obtained in a patient with findings suggestive of systemic lupus erythematosis. Very occasionally the test will be negative in an otherwise acceptable case. Steroids, unless used in massive doses, will usually not reverse the phenomenon. During a prolonged remission, however, some cases will become negative. Patients with rheumatoid arthritis not infrequently, and patients with other diseases, or those receiving certain medications, may also have a positive test. The significance of such a finding is still being debated. A number of individuals with this disease have hematologic, serologic, and chemical abnormalities which, although non-specific, can be helpful in making the diagnosis. Leukopenia is found in a majority of patients, and many have thrombocytopenia. A normochromic normocytic anemia, at times frankly hemolytic and often with a positive Coombs test may be found. Hyperglobulinemia, specifically an increase in the gamma fraction, is a frequent finding. A concomitant reduction in albumin may be anticipated in some patients. A large minority of patients will have a biologic false positive test for syphilis in systemic lupus erythematosis. Abnormal flocculation tests, customarily indicative of hepatic disease may be seen, and are probably a reflection of the protein abnormalities found in the disease. Urinary abnormalities will often be present. Understandably, the erythrocyte sedimentation rate is usually elevated.

In polyarteritis nodosa, urinary findings are common, particularly the presence of albuminuria, hematuria, granular and hyaline casts. Often renal function tests are abnormal. Some of the patients have a mild anemia when seen. A more characteristic hematologic finding is eosinophilia which may be marked. Other findings include serum protein abnormalities and an occasional biologic false positive serologic test for syphilis. These are less constant and are not often helpful in establishing the diagnosis.

There are few laboratory findings of help in diagnosing dermatomyositis. Anemia may be present. At times there is an elevated white count with lymphopenia. A biologic false positive test for syphilis is not characteristic as in systemic lupus erythematosis.

There are no characteristic laboratory findings in scleroderma. Alterations which are found reflect involvement of specific organ systems by the disease.

The presence of thrombocytopenia is of course a hallmark of thrombotic thrombocytopenic purpura. In addition, hemolytic anemia, often with a negative Coombs test, may be seen. Leukocytosis may be present. Occasionally a biologic false positive test for syphilis is seen. Changes within vessels in the bone marrow will be helpful if one is fortunate enough to find these alterations in the aspirated specimen.

A number of non-specific laboratory findings may be expected in rheumatoid arthritis. These include an elevated erythrocyte sedimentation rate, a positive C reactive protein test, an increase in serum globulin, especially the $alpha_2$ and gamma fractions, and decreased albumin. In addition, a number of procedures have been utilized in the past couple decades in an attempt to more specifically demonstrate a rheumatoid factor in the serum of such patients. Streptococcus and sheep cells agglutination procedures have been used to demonstrate the factor. Particles of latex coated with gamma globulin may serve as the indicator system, as in the currently popular latex fixation test. Bentonite, a natural clay, has also been used in a similar manner. Most patients with the disease will have a positive test, although it is seen less frequently in cases of rheumatoid spondylitis and rheumatoid arthritis with psoriasis. A positive result may not be obtained early.

In patients with acute rheumatic fever, it is almost always possible to demonstrate serologic evidence of a prior streptococcal infection. To do this antistreptolysin 0 titers are customarily measured. Usually the titer will exceed 200 units if determined within a few months of onset of the disease. Later, levels may be low. It should be stressed that this finding, although significant, is by no means diagnostic of acute rheumatic fever. Even more non-specific is a positive C reaction protein test and an increased erythrocyte sedimentation rate.

IN DIARRHEAS



Patient: W. O. **Age:** 45 **Sex:** F **Weight** 96

Diagnosis: Functional diarrhea

Results: Definite **Side Effects:** None

Comment: Patient has been on R-1132 (Lomotil) for fifteen months with definite improvement.

ACUTE

RECURRENT

CHRONIC

LOMOTIL® ANTIDIARRHEAL TABLETS/LIQUID

brand of Diphenoxylate Hydrochloride with Atropine Sulfate

PROMPT · SAFE · EFFICIENT



LOMOTIL directly controls the *mechanism* of diarrhea. Therefore, it acts to give symptomatic relief in all diarrheas.

Lomotil promptly arrests acute diarrhea and controls chronic or refractory diarrhea with a high degree of safety.

Pharmacologic considerations indicate that Lomotil acts on the smooth muscle of the intestines and thus lowers the excessive propulsive motility responsible for increased fluidity and frequency of stools. This localized action makes Lomotil unusually free of secondary effects.

By reducing excess propulsive motility, Lomotil assures safe, selective symptomatic control of virtually all diarrheas.

Dosage: For adults the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily. Lomotil maintenance dosage may be as low as two tablets daily.

Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. Recommended dosage schedules should not be exceeded.

Note: Lomotil is an exempt preparation under Federal narcotic statutes.

Detailed information and directions for use in children and adults are available in Physicians' Product Brochure No. 81. G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

G. D. SEARLE & CO.

Research in the Service of Medicine



after surgery: vitamins are therapy

Nutritional supplementation is basic to postoperative care. Therapeutic allowances of B and C vitamins help meet increased metabolic requirements and compensate for stress depletion. STRESSCAPS can set the patient on a more favorable course and contribute to full recovery.

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Harper Hospital Observes Centennial

Several major community and medical events during the week of May 3 helped Harper Hospital climax the observance of 100 years of service to the people of Detroit and Michigan.

The several highlights included at a two-day symposium on "Genetics and Medicine" presented by the Hospital Medical Staff and the Wayne State University College of Medicine; and a Centennial Banquet in Cobo Hall with T. Stewart Hamilton, M.D., president of the American Hospital Association, as the speaker.

The Michigan Civil War Centennial Observance Commission honored the hospital and the City of Detroit with a special memorial citation.

A bronze plaque donated by Parke-Davis will be installed on the lawn of the John R entrance of the Hospital. It will bear the following inscription:

HARPER HOSPITAL

1863-1864

In 1859 Walter Harper and Nancy Martin conveyed land to a board of trustees for the purpose of establishing a hospital. Harper Hospital was incorporated on May 4, 1863. Construction of the hospital buildings began June 13, 1864. Sick and wounded Civil War soldiers, Harper's first patients were admitted on October 12, 1864.

Presented to the City of Detroit under the auspices of the Michigan Civil War Centennial Observance Commission by Parke, Davis & Company on the centennial of the incorporation of Harper Hospital.

At the Symposium on Genetics and Medicine, Professor Kaz Mayeda, of Wayne State University, took the blame off grandmoth-



WALTER HARPER
(1794-1867)



A plaque honoring Harper Hospital was presented by Floyd L. Haight, left, Chairman of the Michigan Civil War Centennial Observance Commission, to Mrs. Tyrus W. Place, Chairman of the Detroit Board of Health and representative of the mayor, and Ray R. Eppert, president of the Harper Hospital Board of Trustees.

ers, at least as far as their role is concerned in influencing erythroblastosis among grandchildren. Doctor Mayeda examined two assumptions when he was studying at the University of Utah, where he studied a group of Mormon mothers. He wanted to find out (1) how far the results of experiments with animals could be applied to humans, and, (2) if grandmothers' blood type was a factor in producing erythroblastosis. Doctor Mayeda discovered that not only do animals behave differently in their capacity for transmitting resistance to blood disease, grandmothers, contrary to commonly held opinion, have nothing to do with the inheritance on the part of the grandchild of a susceptibility to erythroblastosis.

The Symposium program was under the direction of Drs. Gabriel W. Lasker, Edgar E. Martmer, John R. McDonald, Harold C. Mack, and William S. Reveno, all of Detroit.

The Harper Hospital Centennial was directed by many committees, with Eugene A. Osius, M.D., Chief of Staff, as general chairman.

* * *

HARPER HISTORY REVIEWED

Following are excerpts from "Milestones in a Century of Service"—a booklet published during the recent Harper Hospital Centennial celebration.

"Harper Hospital was incorporated under the act of the Michigan State Legislature of March 20, 1863. The land chosen to be the site of the hospital was that near Woodward Avenue and Martin Place, given by Nancy Martin in March, 1859. Although Walter Harper had deeded land for the hospital in February, 1859, it was outside the city limits, beyond the 'Farm Line.' The original Harper Hospital thus stood on Martin land, as does the present hospital.

"The Trustees offered in 1864 to lease land to the government for use as a military hospital to care for Civil War sick and wounded soldiers of Michigan. Construction of the eleven barracks-like buildings which comprised Harper General Hospital was begun by the Army in June and completed on October 12, when it officially opened as a general military hospital.

"In January, 1866, Harper Hospital opened its doors to the general public.

"First sessions of the Detroit College of Medicine, a forerunner of the College of Medicine of Wayne State University, were held in February 1869 in one of Harper Hospital's unused buildings. The medical school offered to take charge of the dispensary. The school removed to its own quarters on Farmer Street in 1883.

"The first microscope for pathological investigation was acquired in 1876.

"Funds became available in 1883 to erect buildings at the rear of 'present hospital buildings' on the four acres between John R and the Brush Farm line.

"The Medical Board in 1888 suggested to the Board of Trustees that 'provision be made as soon as possible for an Out-Patient Department, where the indigent can come for treatment daily (because) one of the signal benefits to a community of the establishment of hospital institutes, consists in the facilities offered to the medical profession and students for the study and advancement of Medical Science.' The out-patient clinic, Harper Hospital Polyclinic, was opened in 1889.

"The Board of Trustees in 1889 approved the erection of a contagious building; Harper Hospital claims to be the first general hospital in the U. S. to accept patients having contagious diseases.

"The first *Harper Hospital Bulletin* was issued in June; it was felt to justify its cost because 'it advertises the Hospital, for cases come to it from all over the state to have operations performed and receive treatment for various diseases.'

"The first x-ray equipment was purchased in 1901—x-rays were discovered only in 1895.

"The medical library was established in 1902.

"During the decade from 1905 to 1915, the medical and legislative worlds bitterly argued the merits of specialization and of hospitals' rights to set qualification standards for physicians who brought their patients into hospitals. Harper's 1910 medical staff reorganization opened the way for specialism, and asserted the hospital's position that it bears a responsibility to the patient to see that only adequately prepared physicians practice within its walls. The Board's 1912 ban on fee-splitting marked another step in the direction of increased hospital responsibility toward its patients; in 1919, the Trustees voted to make Harper a 'closed hospital,' that is, one permitting only duly appointed physicians to use its facilities.

"Harper Hospital in 1916 agreed to organize and staff American Base Hospital No. 17, which was the 'Harper Hospital Unit' activated in World War I. The hospital granted leaves of absence for physicians and nurses to enter military service. The 'Unit,' under the command of Dr. Angus McLean, left for Dijon, France, July 13, 1917; personnel returned March 18, 1919.

"In 1919 Harper Hospital became a member of the American Hospital Association.

"The first electrocardiograph was purchased in 1924 for $700.00.

"In the summer of 1932 the depression began to make itself felt in earnest. Parts of the hospital were closed because patient occupancy dropped drastically. As the depression increased, Harper was forced to lay off employees; many loyally remained although they could be paid only in room and board.

"Harper Hospital officials participated in 1938 in the founding of Michigan Hospital Service, a pioneer Blue Cross plan to insure the costs of necessary hospitalization for much of the community.

"The hospital in 1941 organized its civil defense program: it offered teachers and space for First Aid classes during the 'emergency,' and prepared its buildings to conform with Civil Defense regulations for 'blackout and blast protection.'

"The Seventeenth General Hospital, under the command of Dr. Henry R. Carstens, was reactivated in 1942 for World War II service. Its staff, largely composed of physicians and nurses from Harper saw gallant action in North Africa and Italy.

"In 1945 one of the first post-anesthetic recovery rooms in the U. S. was instituted. Before this, still anesthetized patients had been returned directly to their rooms with a registered nurse in attendance. In the 'P.A.R.,' eighteen patients can receive maximum nursing service with a minimum number of nursing personnel.

"An 'integrated' library combining medical, nursing school, and patients' libraries was opened in 1950. It was one of the earliest in the U. S.

"A research team headed by Dr. F. D. Dodrill conceived

(Continued on Page 600)



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain... not the patient").*

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

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Harper Hospital Observes Centennial

(Continued from Page 598)

in 1951 and developed the first mechanical heart to be successfully used on a human patient. In October, 1952, the American Medical Association awarded Doctor Dodrill and General Motors Research Laboratories a great honor by designating the use of the mechanical heart one of the top ten scientific developments of the year. On September 9, 1954, the original device was presented to the Smithsonian Institution as a permanent exhibit.

"Harper Hospital officially affiliated in 1953 with Wayne State University College of Medicine as one of the several hospitals where undergraduate medical students received their clinical training.

"In July, 1957 the new Emergency Department and Ambulance Entrance opened. Until this time, emergency service could only be given in small quarters on the eighth floor of the Brush Building. With the new facilities, built through the aid of the Ford Foundation, eighteen patients can now be accommodated on the ground floor.

"The inter-denominational Chapel, provided through a gift from the Harper Hospital Auxiliary, opened in 1961.

"The first section of the Medical Center area, including the land surrounding Harper, was condemned in 1962 under the Urban Renewal Act. Demolition of the slum buildings in the neighborhood was begun.

"On November 20, 1962 ground was broken for the Wayne State University Medical Research Building, the first new construction in the Medical Center."

WSU Alumni Elect, Hold Clinic Program

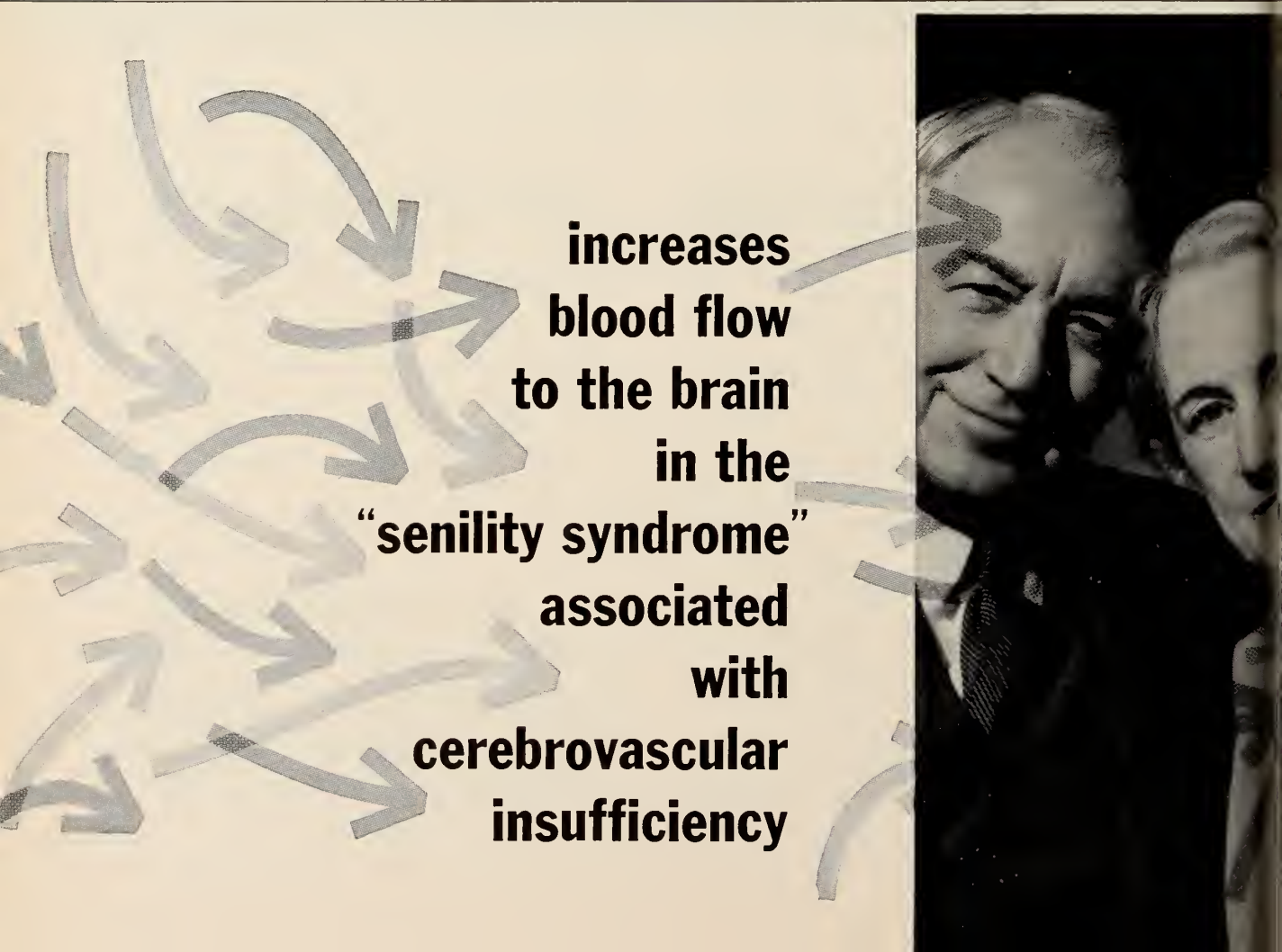
Jacob F. Wenzel, M.D., Grosse Pointe, is the new president of the Wayne State University College of Medicine Alumni Association. He took office May 8, at the 95th Alumni Clinical Program with Hugh W. Henderson, M.D., Grosse Pointe Woods, and Niles Schwocho, M.D., Allen Park, as president-elect and secretary, respectively.

Out-going officers are Herbert W. Devine, M.D., Grosse Pointe, president, and William E. Rush, M.D., Grosse Pointe, secretary.

The new officers will serve for the 1963-64 year which ends May 20, the date of the next Clinical Program and Alumni Reunion Banquet.

At the 1963 banquet, Muir Clapper, M.D., acted as toastmaster. Ernest D. Gardner, M.D., Associate Dean of the College of Medicine, gave a short summary of the Wayne University accomplishments and programs for the last year. The Honorable Thomas B. Adams of the Wayne State University Board of Governors, gave a greeting from the University.

Various classes were recognized at five-year intervals



beginning in 1918 and up to 1958, by the toastmaster.

The Golden Anniversary diplomas were issued to the Class of 1913. There are only four of those still living, and two were present at the meeting: Robert C. Moehlig, M.D., of Detroit, and Dorsey W. Patterson, M.D., of Port Huron. Unable to attend on account of illness: Howard Havers, M.D., and William L. Mayer, M.D., both of Detroit.

The Class of 1963 was introduced and inducted into the Association.

The Alumni Awards were presented by C. Jackson France, M.D., honorary president, to Jon M. Robins, Detroit; Noel S. Lawson, Oak Parks and Helen H. Winkler, Detroit.

Honorary membership was given to Assistant Dean Gardner.

The Distinguished Service Award was presented to Clarence I. Owen, M.D., for a long list of achievements, including the presidency of the Michigan State Medical Society.

The Annual Clinic Day program featured two out-of-state speakers, Mark M. Ravitch, M.D., Baltimore, and Joseph B. Kersner, M.D., Chicago. WSU professors who spoke were Drs. Thomas A. Bruce, Muir Clapper, Elliot D. Luby, Alan P. Thal, Paul V. Wooley, Jr., and Clifford D. Benson.

Blue Shield Honors Retiring Board Members

Six physicians, with a total of 57 years of service on the Michigan Blue Shield Board of Directors, have received a "Certificate of Appreciation" from the Blue Shield Board for "selfless and dedicated service." Their terms on the MMS Board expired last year.

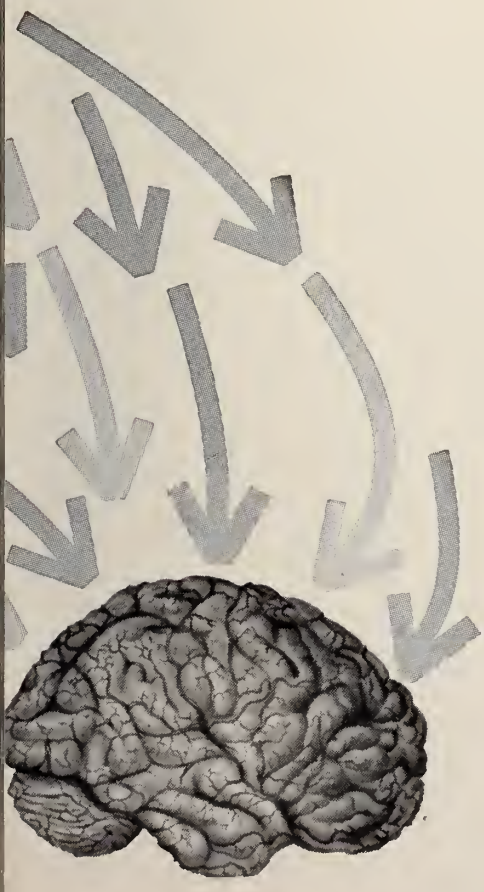
Leading the list is Robert L. Novy, M.D., Detroit, who was president of Blue Shield from 1942 to 1955, more than half the years the plan has operated. He was elected to the Board in 1941, served until 1955, and was re-elected from 1959 to 1962.

Others include James B. Blodgett, M.D., Birmingham, on the Board from 1953-1962; J. S. DeTar, M.D., Milan, director from 1946-1955, also from 1959 to 1962; John W. Rice, M.D., Jackson, 1959 to 1962; Donald W. Thorup, M.D., Benton Harbor, 1953 to 1963; and John M. Wellman, M.D., Lansing, 1955 to 1962.

Blue Shield Sets Rates

Blue Shield raised its rates 19.3 per cent, effective June 1, 1963, on all M-75 contracts, as announced by Frank O. Starr, deputy executive director.

"This rate increase is being put into effect without further



Inadequate cerebral blood flow—often due to cerebral arteriosclerosis—may result in the "senility syndrome" with its pattern of mental confusion, memory lapses, depression, fatigue, apathy and behavior problems.[1-3]

43% increase in cerebral blood flow[4]

In patients with cerebrovascular insufficiency, Eisenberg[4] measured a 43 percent increase in blood flow in the brain following administration of Arlidin (nylidrin HCl) orally for more than two weeks beginning with a dosage of 12 mg. t.i.d. and increasing to 18 mg. t.i.d. There was a decrease in cerebral vascular resistance in most instances.

Winsor and associates[3] found Arlidin (nylidrin HCl) "of particular value clinically in relieving some of the symptoms of cerebral vascular insufficiency (vertigo, lightheadedness, mental confusion, diplopia)."

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While we take pride in reaching our 50th anniversary, as would any company, we realize that product leadership is not something achieved by simply putting in time. We know the pace of progress in electromedicine has gained momentum with every year — that the next *ten* years may well hold a greater challenge to the electromedical equipment manufacturer than the last *fifty!*

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Here are two products that have helped make the Burdick line a leader in the field —

Burdick



EK-III
Electrocardiograph



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— and here are the other Burdick products that share this leadership

ELECTRO-DIAGNOSTIC
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reference to the Insurance Commissioner. It is necessary for Michigan Medical Service to take this action to avert imminent insolvency. The health-care protection for 3.5 million Michigan citizens is at stake," the Blue Shield executive said.

"Three months of discussions with the Insurance Commissioner have proved fruitless. His continued insistence on exceeding his legal authority has left us no choice but to take this action.

"We refuse to bargain away our legal rights. Laws created both our Corporation and the Office of the Commissioner. We ask nothing to which the law does not entitle us. If the price of our survival is to bargain away our legal rights, it is too high a price to pay," Starr said.

"Our subscribers have invested millions with us to provide for them and their families the finest medical-care protection available anywhere in this country. Our action today is taken solely in their best interests—40 per cent of this state's population relies on us. As a private corporation, we must not fail to meet our contractual promises. As a public-service organization, we will not fail to meet our responsibility to these people."

Expand Home Care Coverage

Michigan Blue Cross has approved the Coordinated Home Care Program administered by the Greater Lansing Visiting Nurse Association under the Blue Cross home care program.

This is the fifth expansion since a "pilot" program of home-care coverage by Blue Cross was tried out in Detroit with the Detroit VNA and four hospitals. This program provides home-care coverage for medically selected cases who are discharged from the hospital earlier than would otherwise be possible and whose home environment is adequate for the patient's needs.

Michigan Industrial Medical Association Elects Officers

Members of the Michigan Industrial Medical Association elected officers for 1963-64 at their 38th annual meeting recently at Henry Ford Hospital in Detroit.

Dr. Henry J. Kreulen, medical director for the Fisher Body Division of General Motors Corporation in Grand Rapids, was elected president. He succeeds Dr. William Jend, Jr., medical director for Michigan Bell Telephone Company in Detroit, retiring president.

Dr. Robert D. McIntosh, medical director of the Ternstedt Division of General Motors Corporation in Detroit, was named president-elect. Doctor McIntosh has been serving as a vice president of MIMA.

Dr. Harold J. Magnuson, director of the Institute of Industrial Health at the University of Michigan in Ann Arbor, was elected vice president.

Dr. Benjamin B. Holder, plant physician at Midland for The Dow Chemical Company, was re-elected secretary-treasurer.

Question:

"What is a tranquilaxant?"

Answer:

"A drug that is both a tranquilizer and a muscle relaxant."

TRANCOPAL®
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is a tranquilaxant

As a tranquilizer, TRANCOPAL (chlormezanone/Winthrop) "is effective in the symptomatic treatment of anxiety."[1] Its tranquilizing properties are similar to those of other mild tranquilizers.[1] Furthermore, it relieves tension of both mind and muscle without interfering with normal activity or alertness.

The muscle relaxant properties[2] of this drug provide an extra dimension of effectiveness...relaxing the spasm which so frequently accompanies psychogenic disorders. Hence, the total therapeutic effect of TRANCOPAL (chlormezanone/Winthrop)—a true "tranquilaxant"—is to produce a relaxed mind in a relaxed body.

Unsurpassed Tolerance: Less than 3 per cent of patients develop side effects with TRANCOPAL (chlormezanone/Winthrop), such as occasional drowsiness, dizziness, flushing, nausea, depression, weakness and drug rash. If severe, medication should be discontinued. In most patients, however, side effects are minor and do not necessitate interruption of treatment. There are no known contraindications.

Available: 200 mg. Caplets® (green colored, scored), 100 mg. Caplets (peach colored, scored), each in bottles of 100.

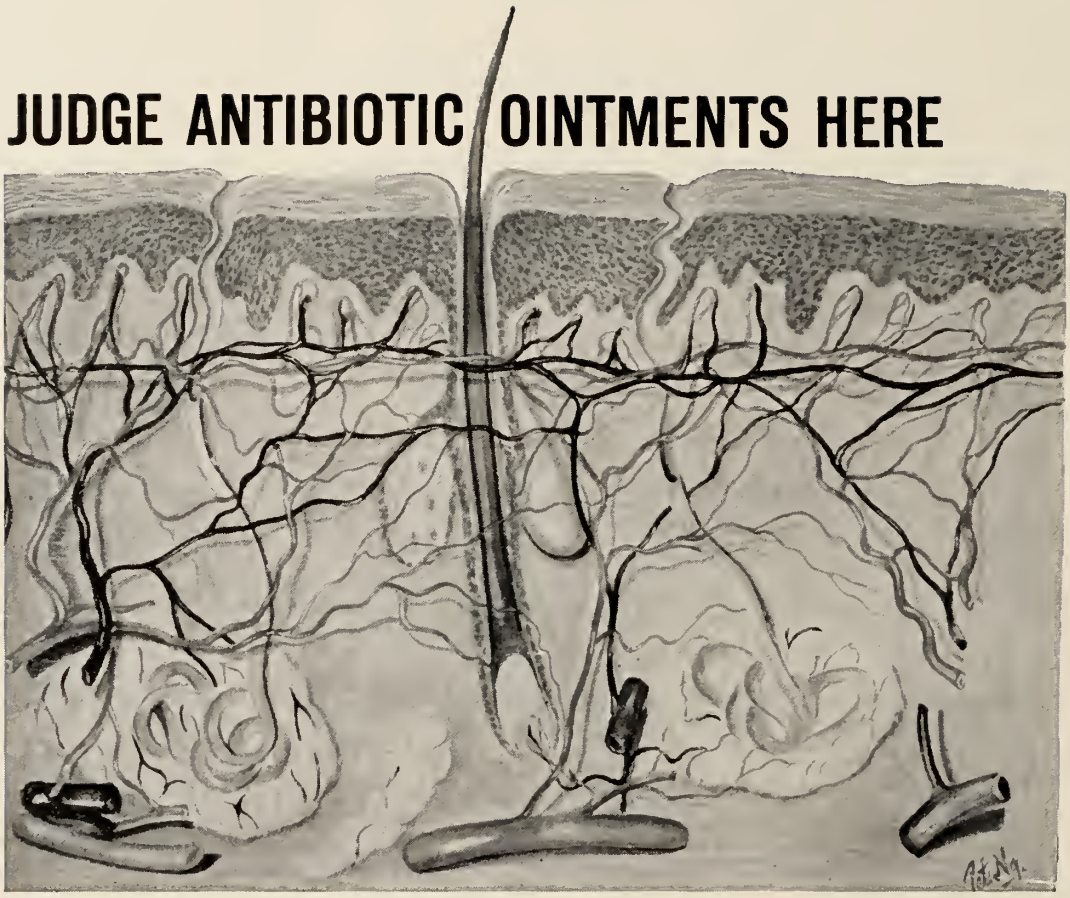
Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; in some patients 100 mg. three or four times daily suffices. Children (5 to 12 years), from 50 to 100 mg. three or four times daily.

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References: 1. A.M.A. Council on Drugs: J.A.M.A. 183:469 (Feb. 9) 1963. 2. Gruenberg, F.: Curr. Ther. Res. 2:1 (Jan.) 1960.

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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

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Review Action Of State Legislature

By M. A. Riley

MSMS Legislative Representative

A "Good Samaritan" law, major revisions in the administration of the State Mental Health Department, authorization for the establishment of community mental health facilities, and upward revision of payments to hospitals and physicians for services to crippled and afflicted children were among the major health bills passed by the just-completed 72nd Michigan State Legislature.

The 80-day legislative session, one of the shortest in recent years, did not result in the passage of any new laws inimical to the best health interests of the people of Michigan. Although they considered over 1,200 individual proposed statutes, the lawmakers exercised sound judgment in medical matters and enacted several bills into law which were endorsed by the MSMS House of Delegates.

The "Good Samaritan" law, which will become effective ninety days following final adjournment of the Legislature on June 7, will assure physicians immunity from civil liability for acts or omissions while rendering emergency treatment (highway accidents, etc.) *unless* in rendering the care the physician is guilty of gross negligence or wanton and wilful misconduct. The bill was recommended by the House of Delegates and was principally supported by the Michigan State Medical Society.

* * *

MENTAL HEALTH LEGISLATION received much attention during this 72nd legislative session, with the lawmakers abolishing the



Governor Romney signs the "Good Samaritan" Law. Watching, left to right, are M. A. Riley, MSMS legislative representative; State Senator Raymond D. Den Dzendzel, introducer of the bill, and Otto K. Engelke, M.D., chairman of MSMS Legal Affairs Committee.



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State Mental Health Commission and substituting a 12-member advisory council appointed by and responsible to the Governor of the state (who will also now appoint an MD Director of this major state agency). Several MSMS-requested amendments were adopted to this proposal before it was enacted into law.

In addition, the legislature has authorized communities, counties or combinations of counties to develop community-oriented mental health treatment facilities which will work with the state Department of Mental Health and be eligible to receive certain matching funds from the state. The new law will create locally appointed community mental health services boards to promote local interest in, and financial support for, mental health programs. Treatment for mental illness will be encouraged on a "close-to-home" basis and increased emphasis will be placed on informational and education services to the public. MSMS assisted in the drafting of portions of this law before its final passage.

The House of Delegates of MSMS also requested a new law which would enlarge the authority of physicians who attend athletic contests so as to provide greater protection to participants. The Society's proposal was enacted into law.

* * *

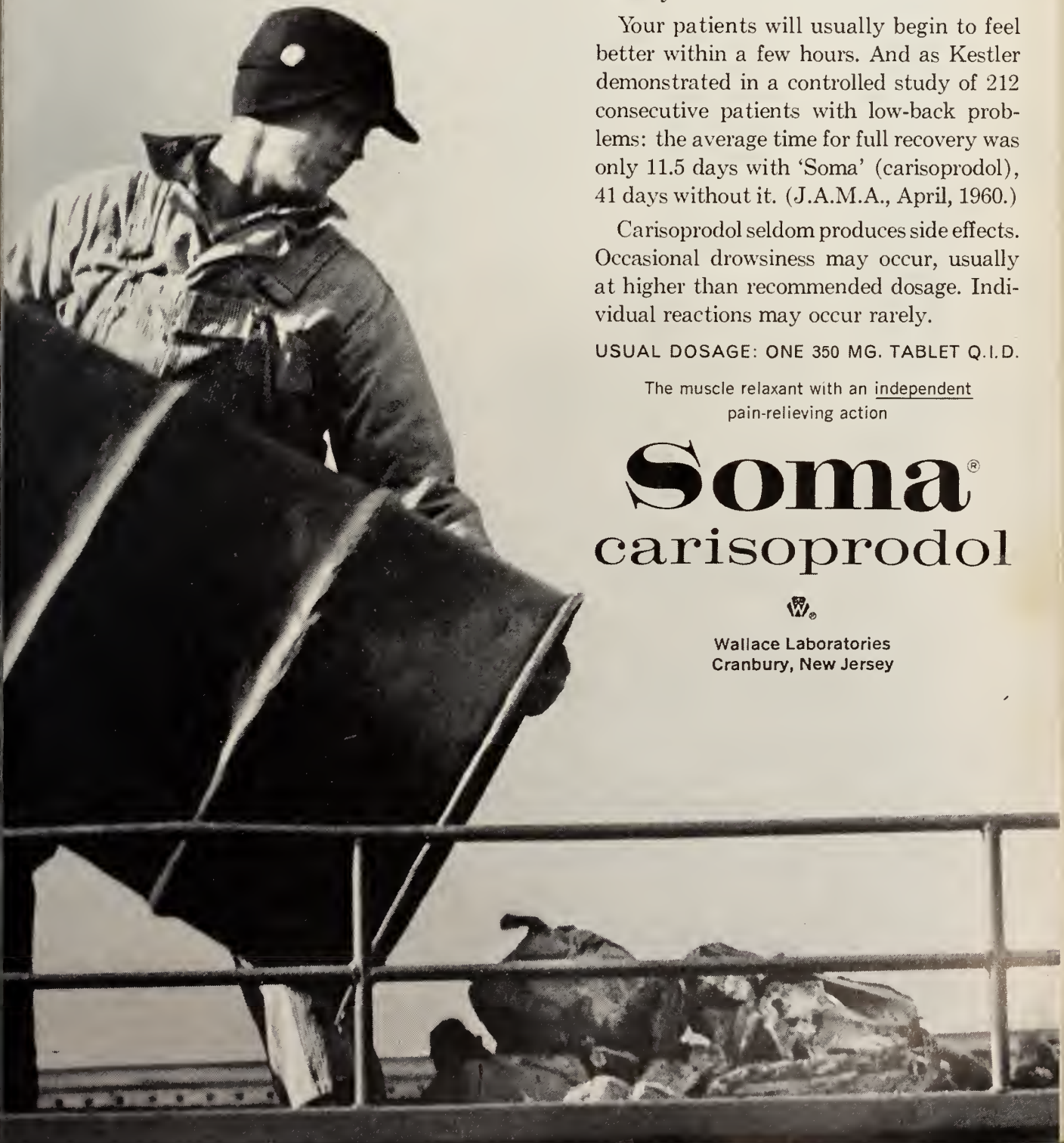
IN OTHER AMENDMENTS passed to existing laws the Legislature removed the existing ceiling on reimbursement to physicians rendering multiple services to crippled and/or afflicted children (was a maximum of $200 in any one year for any one patient); improved the Professional Corporations Act which had been passed with MSMS endorsement in 1962, and simplified the manner in which gifts of human anatomy may be made for teaching and research purposes.

Proposals which were opposed in formal testimony by MSMS and which did not become law included a bill to require a plebiscite to authorize the fluoridation of water, an anti-vivisection proposal, a proposal to authorize the State Labor Department to perform certain health functions, and bills to require a majority of "public representatives" on the Blue Shield Board, among others.

During the interim between June and the convening of the next legislative session in January 1964, special legislative committees will study many matters of vital interest to physicians including tax supported medical care, community hospitals, podiatry, air pollution, fluoridation, Blue Cross and Blue Shield, chiropractic, hospital admittance practices, community mental health and meat, food and milk inspection. In addition, intensive consideration will be given to the reorganization of state government into 20 principal departments as required by the newly-adopted State Constitution, in-

(Continued on Page 608)

Get your low-back patient back to work in days instead of weeks



You can expect rapid results from 'Soma' (carisoprodol)—because this unique drug breaks up both the spasm and pain of low-back syndrome at the same time.

Your patients will usually begin to feel better within a few hours. And as Kestler demonstrated in a controlled study of 212 consecutive patients with low-back problems: the average time for full recovery was only 11.5 days with 'Soma' (carisoprodol), 41 days without it. (J.A.M.A., April, 1960.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely.

USUAL DOSAGE: ONE 350 MG. TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

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Review Action Of State Legislature

(Continued from Page 606)

volving the possible realignment of many health functions.

The State Medical Society will cooperate wherever possible with each of these legislative committees during the Summer and Fall months in an effort to assure that their recommendations are consistent with sound medical and health principles.

Michigan Fourth Highest In Kerr-Mills Payments

Michigan ranked fourth in the nation among the expenditures for Kerr-Mills during the fiscal year ending June 30, 1962. Michigan payments totaled $17,578,000.

The Social Security Administration reports that during the 1961-62 year, a total of $208,752,000 was expended for medical assistance for the aged under Kerr-Mills.

Federal funds accounted for $105,785,000 or 50.7 per cent; state funds, $61,447,000 or 29.4 per cent; and local funds the remaining $41,520,000, or 19.9 per cent.

Twenty-four states participated in this program during the 1961-62 fiscal year, along with Guam, Puerto Rico and Virgin Islands.

New York State alone was responsible for more than one-half the total outlay—$105,402,000. Far behind in second place was Massachusetts, $43,-855,000. Next in order were California, $19,365,000; Michigan, $17,578,000. All other participating states and jurisdictions were in the under-$5 million class.

TREATMENT OF HYPERCHOLESTEROLEMIA

(Continued from Page 575)

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(IN CONJUNCTION WITH ANTITOXIN AND ROUTINE ESTABLISHED THERAPY)
Endocarditis, subacute, bacterial
Genitourinary infection
Gonorrhea
Granuloma inguinale (DONOVANOSIS)
Infections associated with pancreatic fibrosis
Listeriosis
Lymphogranuloma venereum
Meningitis, purulent
Mixed bacterial infection
Osteomyelitis
Otitis
(EXTERNA OR MEDIA)
Pertussis
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MICHIGAN DEPARTMENT OF HEALTH
ALBERT E. HEUSTIS M.D., State Health Commissioner

Phenylketonuria

The Division of Maternal and Child Health of the Michigan Department of Health is currently involved in two projects related to phenylketonuria. One project is part of a national evaluation of a blood test to detect the disease in infants while still in the hospital of birth; the other is aimed at determining the number of Michigan children in special education classes whose mental retardation may have been caused by PKU.

Blood Test Evaluation

The national evaluation of the blood test is sponsored by the Children's Bureau, U. S. Public Health Service, and the Children's Hospital, University of Buffalo. The test was developed by Doctor Robert Guthrie, Department of Pediatrics, Children's Hospital.

The purpose of the study is two-fold: (1) to see if the test developed by Doctor Guthrie will detect PKU before infants leave the hospital of birth and (2) to establish the incidence of the disease in the white population of this country.

During the year of evaluation, 400,000 infants will be tested in hospitals throughout the nation. In Michigan, 22,000 infants will be tested in ten hospitals. Participating hospitals are: Beyer Memorial, Ypsilanti; Blodgett Memorial, Grand Rapids; Henry Ford, Detroit; McPherson, Howell; Mt. Carmel Mercy, Detroit; Oakwood, Dearborn; St. Mary's, Grand Rapids; St. Mary's, Livonia; and St. Lawrence and Sparrow, Lansing.

The procedure is as follows. Three drops of blood are collected by heel puncture from infants who are at least three days old. The blood specimens are sent to the laboratories at the state health department where an inhibition assay test is performed. When the child is three weeks old, the mother collects a urine specimen by means of filter paper and sends it in a special envelope to the state health department laboratories. The urine is then tested and results compared with the result of the blood test. Tests are run at no cost to the parents or hospitals.

Thus far, one positive case of PKU has been discovered in Michigan by means of the screening blood test. This infant, the 4892nd tested in Michigan, had a blood level four times normal on the *second* day of life. A repeat inhibition assay was even higher on the ninth day, with a positive urine level. Paper chromatography of these specimens confirmed the elevated levels.

The infant was sent by the family physician to the University of Michigan Medical Center, Mental Study Unit, Department of Pediatrics and Communicable Disease where Doctor Richard Allen, Director, independently confirmed the diagnosis when the child was 17 days old. The child has been placed on a low phenylalanine diet and the blood levels have come down.

Of particular interest is the fact that the mother of this child has a two-and-a-half-year-old child who had been diagnosed as having cerebral palsy. The mother tested this child's urine at home and got a positive reaction, which was confirmed by a blood test. This child has also been diagnosed as having PKU and is on a trial low phenylalanine diet even though he is probably too old for effective therapy.

Currently, the laboratories of the health department are receiving blood samples from about 1300 infants each month. The urine return rate is about 85 per cent. Thus far 13 cases of PKU have been confirmed nationally with the incidence in the study population of 1 to 10,000 or double the estimated 1 to 20,000 rate in the general population.

Survey Special Education Classes

The second project is one which involves testing the urine of about 17,000 children in classes and training centers for the mentally retarded. This program, conducted by local health department and school personnel, is jointly sponsored by the Department of Public Instruction, the Michigan Association for Retarded Children, and the state health department.

Although the disease cannot be cured once it has affected the mental development of a child, the study is intended to identify children with PKU. At present, it is estimated that about 1 per cent of the institutionalized mentally retarded are there as a result of PKU; the pilot study for this project indicates that half of 1 per cent of retarded children in special education classes are there as a result of PKU.

Since PKU is hereditary, another objective of the

(Continued on Page 612)

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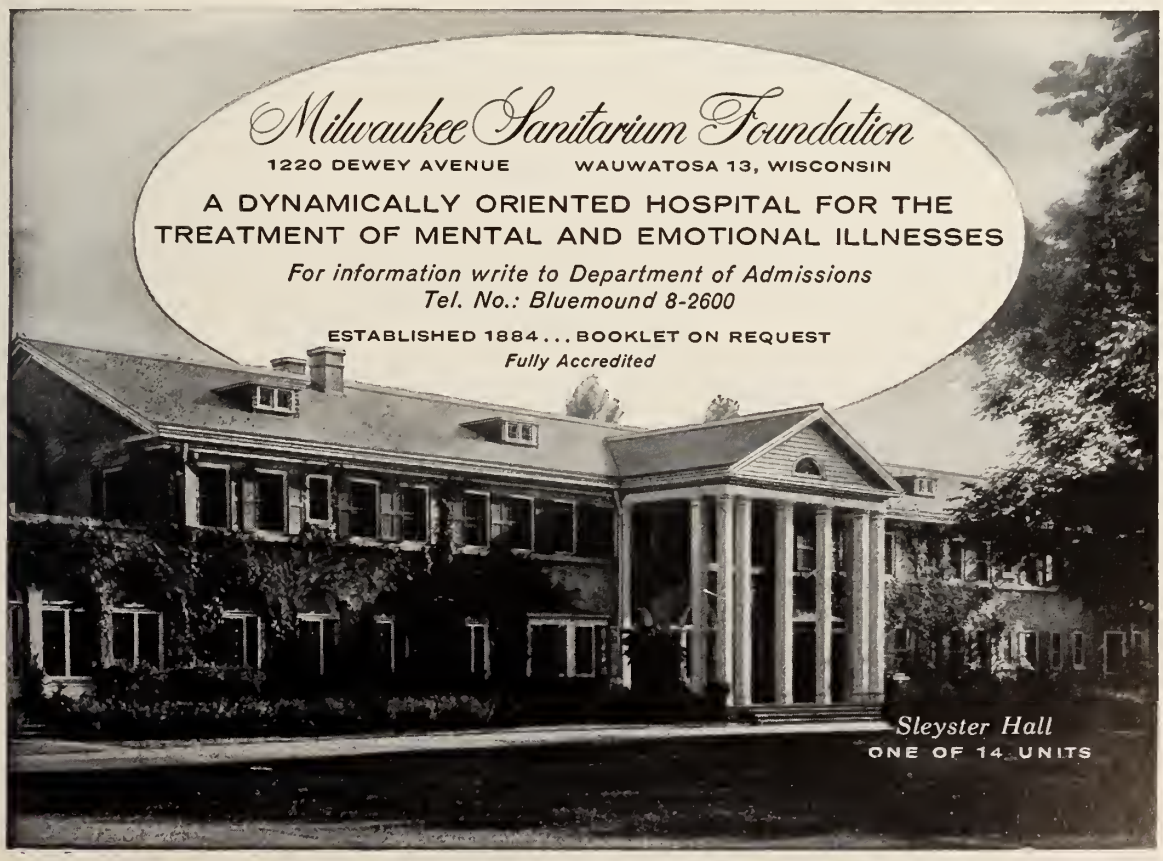
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Phenylketonuria

(Continued from Page 610)

study will be the testing of family members and other relatives. In addition, parents of children previously undiagnosed will be instructed about the disease and its implications for children yet unborn.

* * *

WARNING

On the Use of Michigan Department of Health Immune Serum Globulin in Conjunction with Live Virus Measles Vaccine

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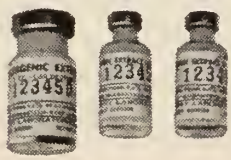
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IN MEMORIAM

JOHN J. COOPER, M.D., 34, Flint general practitioner, died unexpectedly March 21, 1963.

A graduate of St. Louis University School of Medicine, Doctor Cooper served his residency at St. Joseph in 1960.

JAMES E. CURLETT, M.D., 93, of Roseville, Macomb County's oldest practicing physician, died March 31, 1963.

Doctor Curlett, a 1901 graduate of the Detroit College of Medicine and Surgery, had practiced medicine in Roseville for 62 years.

He was a Life Member of the Michigan State Medical Society.

HENRY F. HUGHES, M.D., 90, Cambria physician and Hillsdale County's oldest general medical practitioner, died March 27, 1963.

A graduate of the Detroit College of Medicine and Surgery, Doctor Hughes practiced in Ohio for five years before beginning practice in Cambria in 1905.

Doctor Hughes was a Life Member of the Michigan State Medical Society.

ROLAND P. REYNOLDS, M.D., 64, Detroit surgeon, died April 4, 1963.

A graduate of the University of Western Ontario, Doctor Reynolds had offices in the Fisher Building. He was chief of surgery at Grace Hospital from 1949 to 1959 and served as chief of staff from 1950 to 1961. He was a member of the American College of Surgeons.

LOUIS J. STEINER, M.D., 60, Detroit physician, died March 27, 1963.

A graduate of Wayne University College of Medicine in 1928, Doctor Steiner had been associated with Henry Ford Hospital since that time, first as intern and resident and later as a staff member. His positions at the hospital included physician in charge of industrial medicine and occupational diseases, and of preventive medicine. He also was chief examiner and adviser to the Ford Motor-UAW Retirement Board, special examiner for the National Association of Life Insurance Examiners, and medical examiner for the Federal Aviation Agency.

MICHIGAN MEDICAL MEETINGS

Annual Claude Keyport Trauma Day, June 19, Hidden Valley, Gaylord.

Upper Peninsula Medical Society, June 28-29, Sault Ste. Marie.

Coller-Penberthy Clinic, July 25-26, Traverse City.

Michigan State Medical Society Annual Session, September 25-27, Grand Rapids.

Midwest Regional Group of Medical Library Association, October 3-5, Bronson Hospital, Kalamazoo.

Hospital Section of Michigan Library Association, October 18, Bancroft Hotel, Saginaw.

Alumni Conference, Michigan Medical Center, October 18-19, Ann Arbor.

Brief and to the Point

HONORED BY WSU—Wayne State University at its 95th Annual Reunion, May 4, cited five alumni, including Marion W. Jocz, M.D., Grosse Pointe. Dr. Jocz is a graduate of the College of Medicine and is medical director for the Chrysler Corporation. Under his leadership Chrysler has gained national recognition for its medical program receiving the 1961 National Health Achievement Industry Award from the Industrial Medical Association. He also is a member of the board for the WSU College of Medicine Alumni Association.

ELECTED—E. Osborne Coates, M.D., Detroit, has been re-elected president of the Michigan Thoracic Society, medical affiliate of Michigan Tuberculosis and Respiratory Disease Association.

Also re-elected were John L. Isbister, M.D., state TB controller, vice president, and Edward J. Nedwicki, M.D., chief of the tuberculosis division of Veterans Hospital, Dearborn, secretary-treasurer.

HONORED—James V. Neel, M.D., Ann Arbor, has been elected to membership in the National Academy of Sciences by the Section of Zoology and Anatomy. Three other U-M Medical School professors have attained Academy membership.

FORD GRANT—The University of Michigan Medical School will receive $26,000 from the Ford Foundation for use as stipends for student research on reproductive biology. The students will do research in those areas of reproductive biology relevant to fertility control.

FELLOWS—Ten Michigan physicians were honored by the American College of Physicians. Designated as Fellows were: Doctors Richard D. Judge, of Ann Arbor; Arthur K. Kamp, Allison R. VandenBerg and Keith E. Weller, all of Grand Rapids; William H. Kelly, of Lansing; and George Ritter, of Lathrup Village. Selected as Associates were: Doctors Kenneth B. Herrington, of Bad Axe; Robert H. Hamburg and Richard D. Sills, both of Detroit; and Eugene S. Austin, of Owosso.

REUBEN KAHN HONORED—Dr. Reuben L. Kahn, Ann Arbor, emeritus member of the University of Michigan Medical School Faculty, has received an honorary doctor of medicine degree from the faculty of the National University Medical School at Athens, Greece. The unusual honor came in concert with Dr. Kahn's 50th year of scientific publications. He has had 226 publications over the half-century. After the ceremony, Dr. Kahn delivered an oration on the subject of "Tissue Immunity and Irradiation." (JMSMS October 1948 was dedicated to Dr. Kahn on his 25th anniversary.)



SPEAKER—Reed O. Dingman, M.D., Ann Arbor, presented a paper on "The Management of Facial Injuries" at the recent sectional meeting of the American College of Surgeons in Toronto.

* * *

LEADER—Conrad R. Lam, M.D., Detroit, has been appointed chairman of the Yale Medical School Alumni Fund for a three-year term. Dr. Lam previously served the Alumni Fund as regional chairman for Michigan.

* * *

JOIN U-M—Joseph E. Hawkins, Jr., M.D., and Nathan B. Gross, M.D., have been appointed to the staff of the Kresge Hearing Research Institute staff and to professorships with the University of Michigan Medical School, effective September 1. Dr. Hawkins formerly was with the New York University Medical Center; Dr. Gross was at Lehigh University.

* * *

WINNER—Walter B. Forman, of Oak Park, won the Student American Medical Association-Mead-Johnson Science Forum First Prize for his paper on "The Cellular Site of Fibrinogen Synthesis". The 24-year-old senior at Wayne State University College of Medicine presented his research paper to SAMA on May 3 and at the AMA meeting in Atlantic City, in June.

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HONORED BY ACOG—The American College of Obstetricians and Gynecologists announces that the following new Michigan Fellows recently were inducted into the College: Francis A. Locke, M.D., Adrian; David G. Anderson, M.D., and Richard A. Kutcipal, M.D., Ann Arbor; Kenneth I. Ranney, M.D., Birmingham; Thomas DeLawrence, M.D., Dearborn; Alan C. Lakin, M.D., Kamran S. Moghissi, M.D., and Donald C. Swan, M.D., all of Detroit; Harrison C. Visscher, M.D., East Grand Rapids; H. E. Malcolm, M.D., East Lansing; Sidney F. Katz, M.D., Farmington; Harold E. Veldman, M.D., Grand Rapids; Joseph A. Caruso, M.D., and Richard S. Johnson, M.D., both of Lansing; William E. Harrigan, M.D., Midland, and William A. Starbird, M.D., Warren.

* * *

MODERATORS—Two Michigan doctors spoke at the annual meeting of the American Thoracic Society in Denver recently. Paul T. Chapman, M.D., Detroit, was moderator for a discussion of "New Role of the OPD in Tuberculosis," and Winthrop N. Davey, M.D., Ann Arbor, was moderator for "Etiologic Aspects of Newer Environmental Lung Disease."

* * *

STUDENT HONORED—Frederick Neinas, junior, Wayne State University College of Medicine, was one of 10 medical students named as national winners of the Student American Medical Association-Sears Preceptorship Scholarships. The $500 scholarships will enable Mr. Neinas to work this summer with a practicing rural Michigan physician.

* * *

SPEAKER—The eighth annual Michigan State Dental Association's District Officers' Conference in Detroit, May 5, featured Richard C. Bates, M.D., Lansing.

* * *

ELECTED NATIONAL PRESIDENT—Dr. Myron E. Wegman, dean of The University of Michigan School of Public Health, was elected president of the Association of Schools of Public Health at the annual meeting in Chapel Hill, N. C., April 10. The association is composed of all accredited Public Health Schools in 14 universities throughout the United States and Canada. Doctor Wegman takes office immediately for a one-year term, succeeding Dr. Hugh Leavell of Harvard University.

* * *

STUDY INDIGENT CARE—Drs. John Fopeano, James Malone and Homer Stryker have been appointed as representatives of the Kalamazoo Academy of Medicine to a study committee requested by the Kalamazoo County Board of Supervisors to plan for long-term care of indigent patients in Kalamazoo county.

* * *

YALE CENTER MOVES—The Yale Center of Alcohol Studies has been moved to the Rutgers University Campus in New Brunswick, N. J. The center, opened at Yale in 1921, holds annual summer courses on the alcoholism problem.

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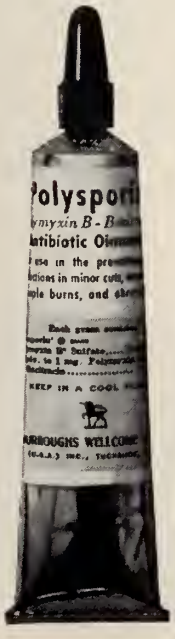
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Letters to the Editor

Dear Dr. Haughey:

In the April 1963 issue of the Michigan State Medical Society Journal, there is an article, "Addition of Hydriotic Acid in the Treatment of Respiratory Distress" by A. R. Ceresko, M.D.

This article has considerable interest because I have used the syrup of hydriodic acid in a prescription for bronchial asthma for over 30 years with great success. And the second point of interest in the article is that the author probably means hydriodic acid instead of hydriotic acid. There does not appear to be an acid called hydriotic acid.

Very truly,

C. E. Reyner, M.D.

Detroit, Michigan
April 18, 1963

Dear Dr. Haughey:

That 3099 Michigan physicians should endorse further extension of social security legislation disturbs me. Ray Peterson's essay "The Coming Din of Inequity," JAMA, April 8, 1961, should be required reading. Mr. Peterson, an actuary and Vice President of the Equitable Life Assurance Society of the U. S., has this to say:

"Today [in 1961] the average *new* self-employed person is paying 20 per cent more than the value of his benefits. The taxes payable by and in respect of the new entrant must *forever* be greater in value than the value of the benefits that the new member will receive. *The price of social adequacy is perpetual individual inequity.*" [his italics]

Vincent Burke in *Nation's Business* for August, 1962, (p. 87) states:

"The self-employed tax rate by 1968 is scheduled to climb to 6.9 per cent. There has been no official announcement of the present average cost of benefits for a new entrant into the social security system, but it apparently is not much above 5 per cent of taxable payroll."

Are the 3100 Michigan physicians who favor inclusion in the social security program aware of these and similar facts?

Sincerely,

Robert E. Fisher, M.D.

Battle Creek, Michigan
May 8, 1963

Dear Dr. Haughey:

A paper of mine entitled "The Roles of Estrogen and Progesterone in Breast and Genital Cancer," published in *The Journal of the American Medical Association*, continues to attract considerable attention [JAMA, 182:327-331 (Oct. 27) 1962]. Requests for reprints continue to arrive; many from abroad and from behind the Iron Curtain. This paper concludes: "The evidence presented indicates that estrogen and progesterone are prophylactic to breast and genital cancer to an unknown degree. It is urgent that this process be intensively investigated. It would seem advisable to keep women endocrine-rich (estrogen-progesterone) and consequently, cancer-poor throughout their lives. A consequence of this would be the elimination of the menopause." In 2387 years of patient-exposure to exogenous estrogen, no breast or genital cancers occurred although 18 was the expected incidence.

A related article entitled "The Fate of the Nontreated Postmenopausal Women, A Plea for the Maintenance of Adequate Estrogen from Puberty to the Grave" by R. A. Wilson and T. A. Wilson, appears in the April issue of *The Journal of the American Geriatrics Society*. In this article, it is shown that the menopausal woman is not normal; she suffers from a deficiency disease with serious sequelae and, without exception, needs treatment.

A third and key paper by R. A. Wilson, H. T. Hagstrom, R. E. Brevetti and T. A. Wilson, entitled "Specific Procedures for the Elimination of the Menopause" will appear with an accompanying editorial in the May-June issue of *The Western Journal of Surgery, Obstetrics and Gynecology*. If the suggested appropriate methods are employed, a woman approaching the climacteric will not experience it, and the postmenopausal woman will be restored quickly to the premenopausal state. The degree of feminity (estrogenicity) of any woman whether young, perimenopausal, or postmenopausal, can be easily determined by an analysis of the percentages of superficial, intermediate and parabasal cells in the Papanicolau smear. This cytohormonal assay is the only practical guide in the management of the menopause.

Today the menopause is as obsolete as the bow and arrow. No woman need experience it or live with its cumulative effects. The re-education of almost every man, woman and physician in the civilized world is needed.

I feel certain that you will find this effort towards the final emancipation of women of interest.

Very truly yours,
Robert A. Wilson, M.D.

Brooklyn, New York
April 11, 1963

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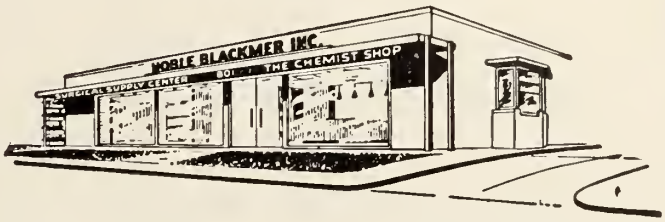
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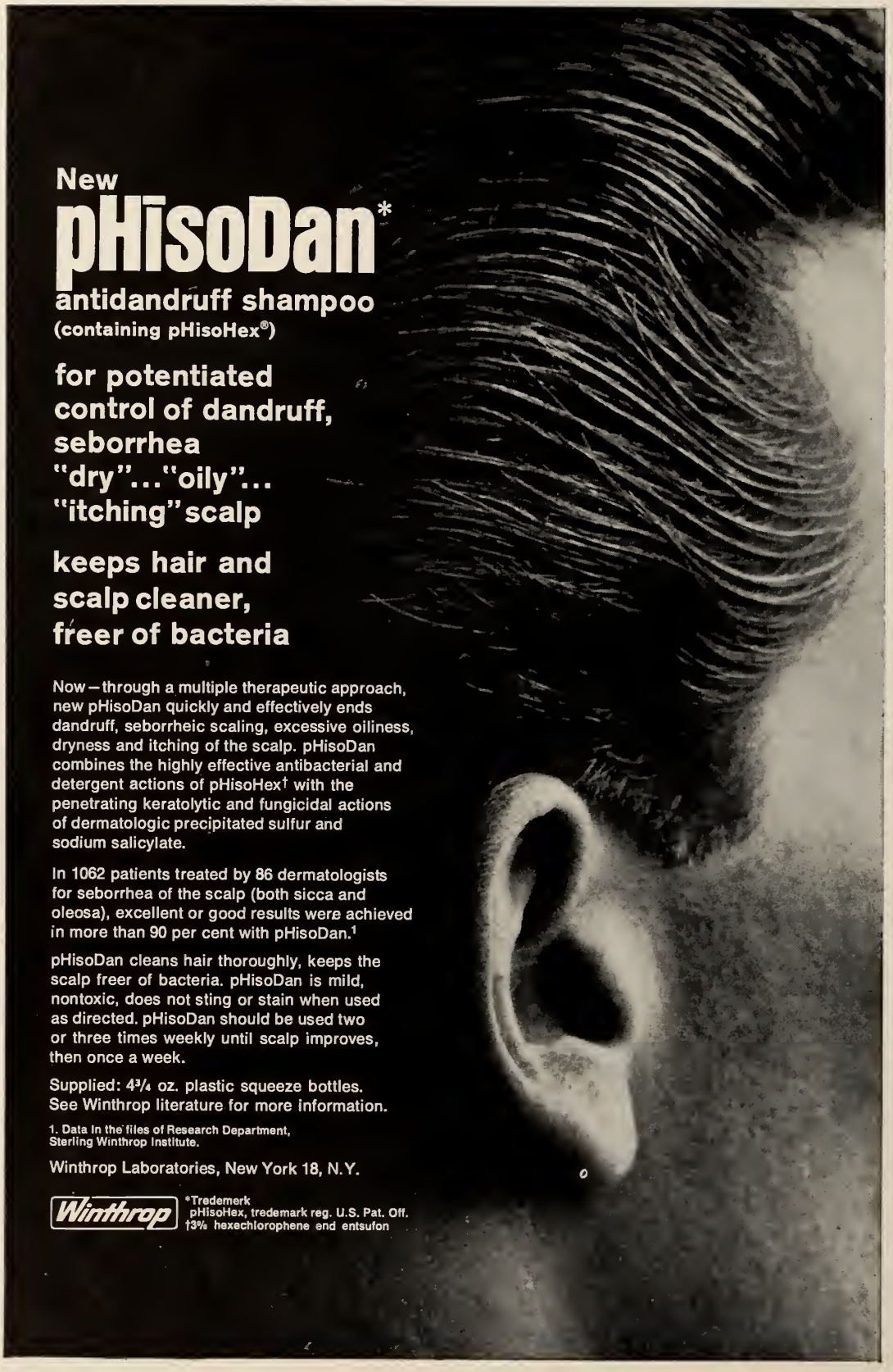
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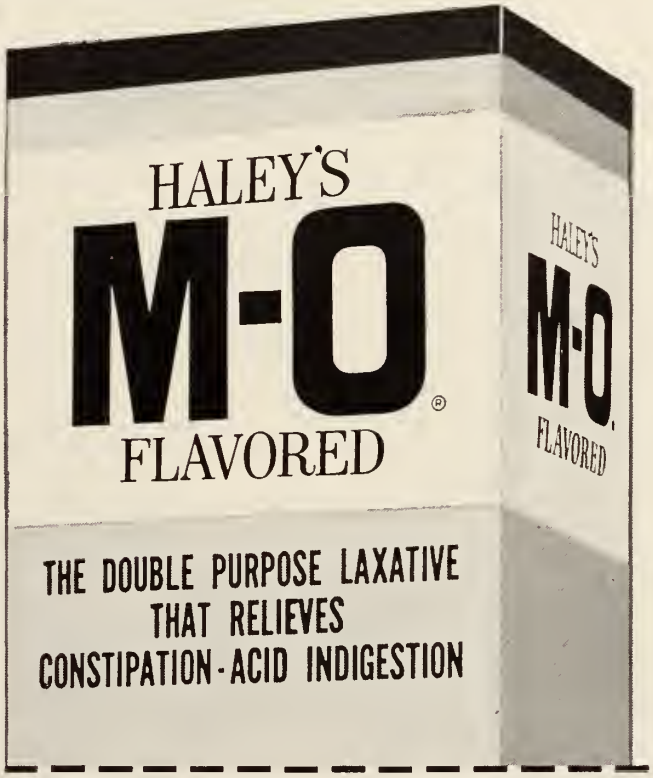
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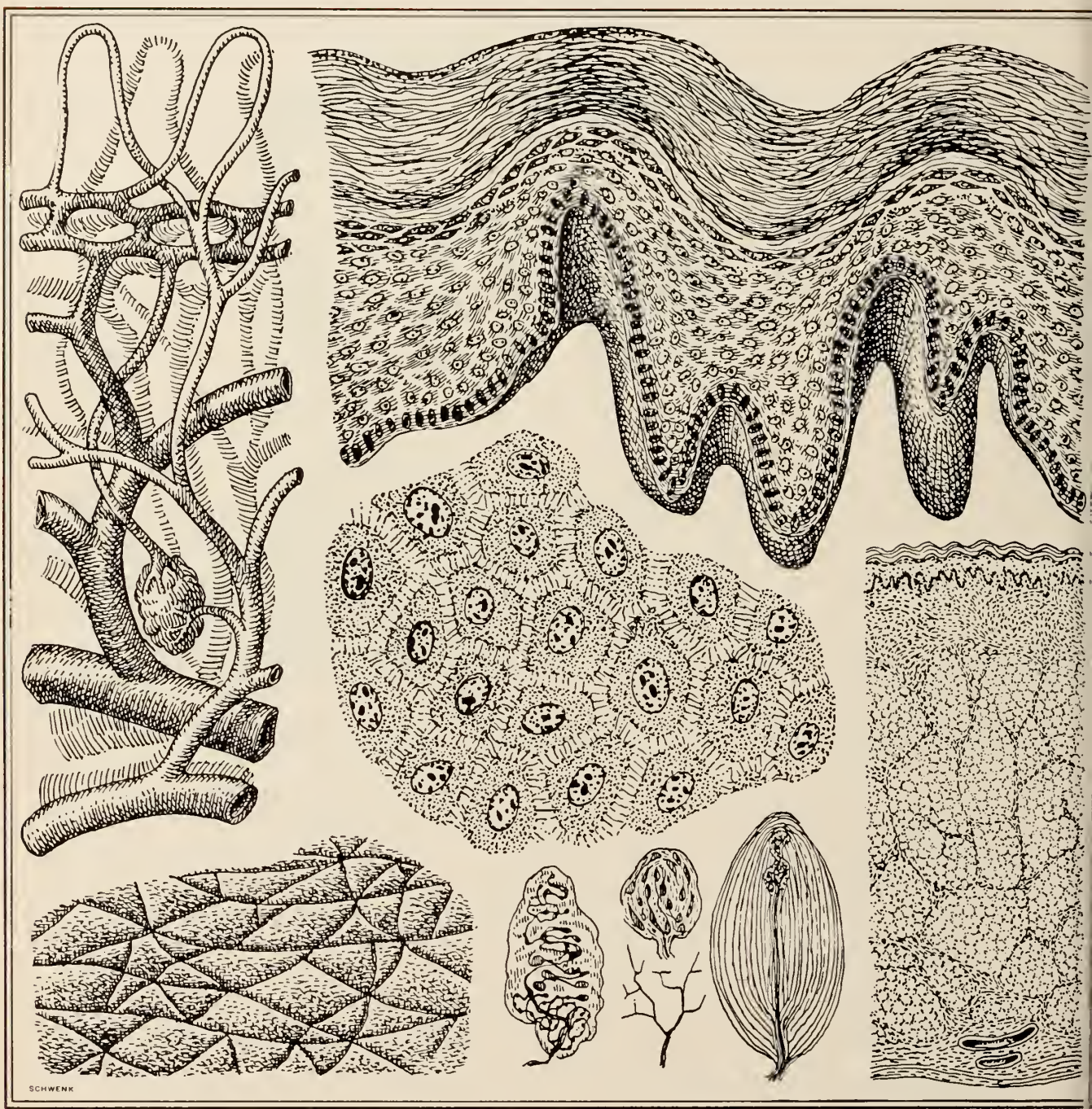
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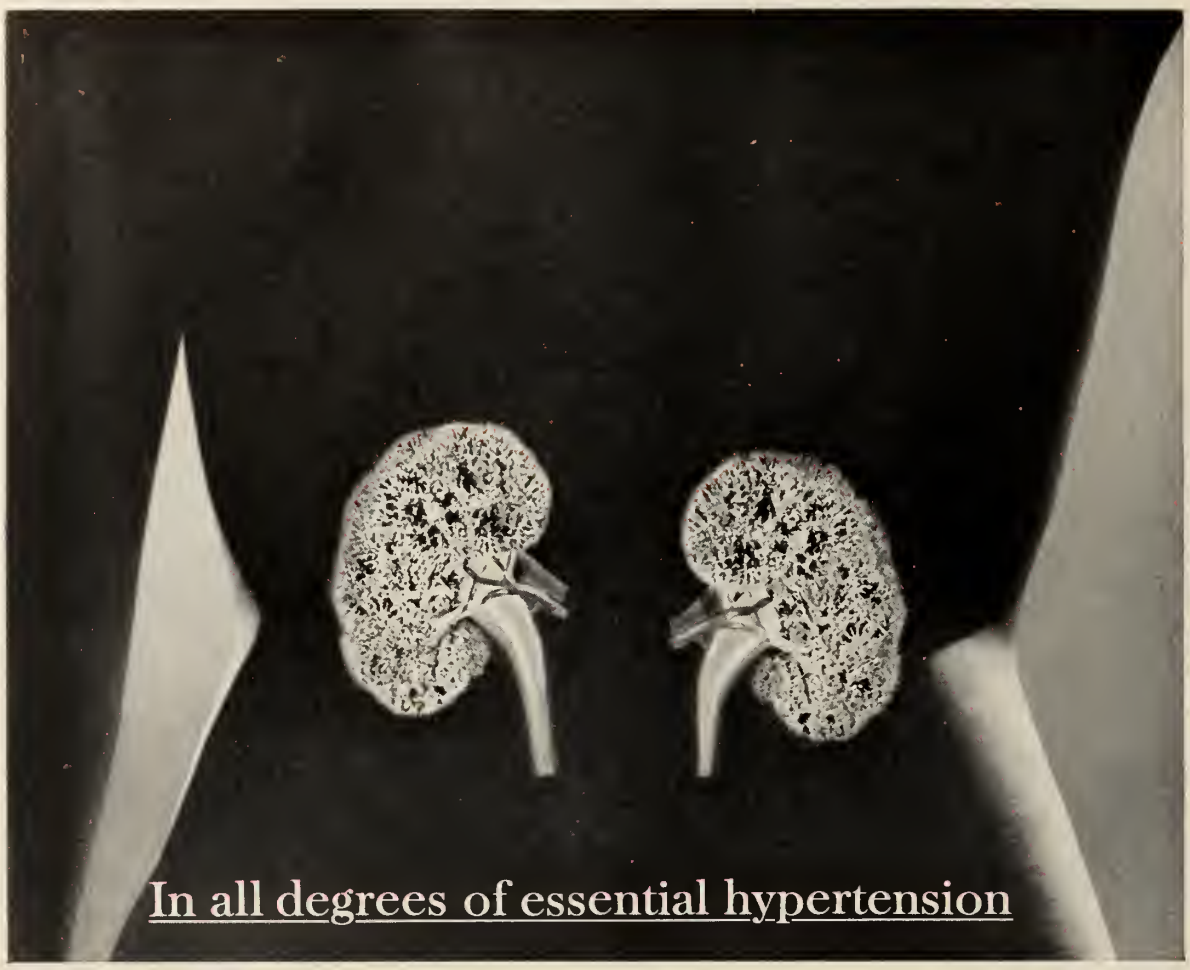
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Serious Business

(The following article was written for and published in the *Detroit Medical News*, January 29, 1962. It seems appropriate to reprint it at this time, in view of the recent "crisis" between the State Insurance Commissioner and Blue Cross-Blue Shield)

The October 9, 1961, issue of *Medical Economics* carried an abstract of a copyrighted pamphlet entitled "The Case for Socialized Medicine" written by R. W. Tucker. The gist of the article was that medicine will be socialized soon because the cost of medical care is rapidly becoming too expensive for the average citizen. This editorial was prompted by the implications for American Medicine found in that article which I hope you have read.

It is the duty of everyone in medicine who has to do with medical costs to patients to be fully aware of the economic situation in medicine as it exists today. This concerns not only practicing physicians but also hospital management, purveyors of medical supplies and drugs and ancillary medical services.

One certain way to "socialize" medicine is to permit costs to continue to rise and to allow savings of families to be exhausted paying for medical and hospital care. Frequently statistics are quoted to show that medical costs are rising and will continue to rise at a greater rate than living costs in general. This is in spite of the fact that physicians' fees are rising at a lesser rate than living costs.

The U.S. Department of Commerce reported in July, 1961, that in the twenty year span since 1940, the medical care dollar has gone up from eighteen cents to twenty-six cents for hospitals and from five cents to eight cents for health insurance, while drugs have dropped from twenty-one cents to twenty cents and physicians' fees from thirty cents to twenty-five cents.

Nevertheless, the rapid increase in the past few years in the overall costs of medical care should be of deep concern to all physicians. We know that unless the medical care dollar is spent wisely and efficiently, the time will come when the average family will not be able to pay for hospitalization, physicians, nurses and other medical costs or even their health insurance.

Hence the physician must critically analyze every item in every patient's care from an economic as well as scientific and professional standpoint. He must do this for all patients whether or not they have insurance since in the last analysis, the insurance money must come from the policyholder.

The physician must ask himself questions such as the following:

1. Am I prescribing the lowest cost drug which will accomplish the desired therapeutic results?
2. Is this diagnostic test really necessary? Is it a duplication of one already performed?
3. Is this hospitalization necessary?
5. Do I really need this expensive consultation for the proper management of this case?
4. Is this hospital stay being needlessly prolonged?

(Continued on Page 632)

President's Page

(Continued from Page 631)

Hospital staff and audit committees and outside accrediting boards and councils must likewise keep costs in mind when standards are set. Hospital management and educators also must participate in this determined effort. There must be an agonizing reappraisal of whether certain costs such as education, medical research and staff projects should be charged against patient care.

The socialists are content to run a harassing campaign gaining a point here and there waiting for us to "hang" ourselves as medical services are priced out of reach. If this continues more and more patients and families will look to government for their medical care. When the situation is ripe, the socialists will step in for the "kill" without any particular effort on their part. Federal medicine, with all its detestable features, will then become a reality.

But we must not assume a defeatist attitude. We can and must win this battle against socialism and socialized medicine. But in order to do so we must be realistic. If we lose, a brilliant chapter in medical history will be replaced by a bureaucratic government-controlled, operated and financed system of medical care with mediocrity as its standard.

The chips are down. We must win.

MSMS Annual Scientific Session Is Deductible

The income tax collector won't interfere with the attendance by every MSMS member of their 1963 Annual Scientific Session in Grand Rapids. It may not be possible for every member to participate—that will be too bad, but it cannot be blamed on the Internal Revenue Service.

Special dispensation from the rules on entertainment is given by the IRS to taxpayers attending conventions and other meetings of tax-exempt trade associations and professional societies. Among the exceptions in the regulation is (2) (f) (vii) saying, "Any expenditure for entertainment directly related to and necessary to attendance at bona fide business meetings or conventions of organizations exempt under section 501(c) (6), such as business leagues, chambers of commerce, boards of trade and certain professional associations, is not subject to the limitations on allowability of deductions provided in paragraphs (a) through (e) of this section."

Another easy-to-overlook provision eliminates an earlier ambiguity by clearly stating that "entertainment" means one's own expenses as well as those which are incurred in wining and dining others. General rules (2) (b) (1) (i) says, "The term means any activity which is of a type generally considered to constitute entertainment, amusement or recreation . . . including such activity relating solely to the taxpayer or the taxpayer's family. (It) generally includes any expenditure incurred in satisfying the personal, living, or family needs of any individual which is claimed as a business expense by the taxpayer."

Michigan Medical Meetings

Coller-Penberthy Clinic, July 25, 26, Traverse City.
University of Michigan "Hospital-Internship Day," August 14, Medical Science Building, Ann Arbor.
Michigan Medical Service annual meeting, September 24, Grand Rapids.
Michigan Medical Assistants Society annual meeting September 25, 26 at Sims Inn, Grand Rapids.
Michigan State Medical Society Annual Session, September 25-27, Civic Auditorium-Pantlind Hotel, Grand Rapids.
Woman's Auxiliary of Michigan State Medical Society annual meeting September 24-27, Pantlind Hotel, Grand Rapids.
Midwest Regional Group of Medical Library Association, Oct. 3-5, Bronson Hospital, Kalamazoo.
Hospital Section of Michigan Library Association, October 18, Bancroft Hotel, Saginaw.
Alumni Conference Michigan Medical Center, October 18-19, Ann Arbor.

Blue Cross MD Enrollment Up

During the recent re-enrollment period, Michigan Blue Cross added new contracts for 75 MSMS members. Blue Cross reports that it now covers 4,454 members.

MSMS Journal Selected For US Referral Center

THE JOURNAL of the Michigan State Medical Society is one of the publications selected by the Library of Congress Referral Center for Science and Technology for its continuing inventory. Information about THE JOURNAL will now be available to scientists and organizations seeking aid and assistance.

The Library of Congress explains that the new Referral Center "will assist in assuring improved communications in the scientific and technical community."

Hear Medical Authorities At MSMS Annual Session

The 1963 Annual Session offers Michigan State Medical Society members many outstanding medical authorities on a wide range of subjects. The 98th Annual Session will be held at the Pantlind Hotel-Civic Auditorium in Grand Rapids.



General Information

DATES	*House of Delegates*—Sunday, September 22, 8:00 p.m.; Monday, September 23, 9:00 a.m. and 8:00 p.m.; Tuesday, September 24, 9:00 a.m. and 8:00 p.m. *Scientific Session*—Wednesday, September 25, 9:00 a.m. to 5:30 p.m.; Thursday, September 26, 9:00 a.m. to 5:30 p.m.; Friday, September 27, 9:00 a.m. to 12:30 p.m.
HEADQUARTERS	Pantlind Hotel and Civic Auditorium, Grand Rapids
REGISTRATION	*House of Delegates*—Lobby of Pantlind Hotel, Sunday, September 22, 6:00 p.m. through Tuesday, September 24 adjournment of House of Delegates *Scientific Session*—Civic Auditorium, Grand Rapids; Wednesday, September 25, 9:00 a.m. to 5:30 p.m.; Thursday, September 26, 9:00 a.m. to 5:30 p.m.; Friday, September 27, 9:00 a.m. to 12:30 p.m. NO REGISTRATION FEE FOR MEMBERS OF MSMS AND OTHER STATE MEDICAL ASSOCIATIONS, AMA, AND CANADIAN MEDICAL ASSOCIATION. Please have your membership card ready.
EXHIBITS	Civic Auditorium, Grand Rapids; Wednesday, September 25, 9:30 a.m. to 5:00 p.m.; Thursday, September 26, 9:30 a.m. to 5:00 p.m.; Friday, September 27, 9:30 a.m. to 1:00 p.m.
NEWS ROOM	House of Delegates—Sadler Lounge, Pantlind Hotel Scientific Session—Room F, Civic Auditorium

You Are Invited To Annual Dinner Dance



EDWARD R. ANNIS, M.D.
Biddle Lecturer

Once again, the "State Society Dinner Dance" will be the social highlight of the MSMS Annual Session at Grand Rapids, Thursday, September 26, in the Civic Auditorium. Ticket will entitle you to the cocktail hour, a delicious dinner, dancing, a talk by American Medical Association President Edward R. Annis, M.D., of Miami, Florida, and a stellar stage show.

You'll enjoy fun . . . entertainment . . . and fellowship.

Scientific Assembly Program For 1963 Annual Session

Wednesday-Thursday-Friday, September 25-26-27
Black and Silver Ballroom, Civic Auditorium, Grand Rapids

9:00 a.m. to 5:30 p.m. on Wednesday and Thursday
9:00 a.m. to 12:30 p.m. on Friday

Wednesday Morning, September 25

9:00 a.m. Panel on
"FERTILITY AND INFERTILITY"
Moderator: *Samuel J. Behrman, M.D.*, Ann Arbor, Michigan
Participants: *Robert W. Noyes, M.D.*, Nashville, Tennessee
Robert W. Kistner, M.D., Brookline, Massachusetts

10:00 a.m. *Intermission to View Exhibits*

11:00 a.m. Panel on
"CEREBRAL VASCULAR ACCIDENTS"
Moderator: *Russell N. DeJong, M.D.*, Ann Arbor, Michigan
Participants:
(Neurologist) *Clark H. Millikan, M.D.*, Rochester, Minnesota
(Internist) *Irving S. Wright, M.D.*, New York City
(Neuro-surgeon) *Elisha S. Gurdjian, M.D.*, Detroit, Michigan
(Radiologist) *Juan M. Taveras, M.D.*, New York, New York

12:30 p.m. Luncheon and Section Meetings

Wednesday Afternoon, September 25

2:00 p.m. Panel on
"ENDOCRINOLOGY OF PREGNANCY"
Moderator: *Wm. W. Jack, M.D.*, Grand Rapids, Michigan
Participants: *Allan C. Barnes, M.D.*, Baltimore, Maryland
Wm. H. Beierwaltes, M.D., Ann Arbor, Michigan

3:00 p.m. *Intermission to View Exhibits*

4:00 p.m. Panel on
"RENAL FAILURES"
Moderator: *James M. Pierce, Jr., M.D.*, Detroit, Michigan
Participants:
(Urologist) *Wm. L. Parry, M.D.*, Oklahoma City, Oklahoma
(Internist) *George E. Schreiner, M.D.*, Washington, D. C.
(Pediatrician) *Wm. J. Oliver, M.D.*, Ann Arbor, Michigan
(Surgeon) *Samuel R. Powers, Jr., M.D.*, Albany, New York

Thursday Morning, September 26

9:00 a.m. Panel on
"MANAGEMENT OF CARDIAC ARREST AND ARRYTHMIAS"
Moderator: *Park W. Willis, III, M.D.*, Ann Arbor, Michigan
Participants: *Herbert E. Sloan, M.D.*, Ann Arbor, Michigan
Bernard Lown, M.D., Boston, Massachusetts

10:00 a.m. *Intermission to View Exhibits*

11:00 a.m. Panel on
"DISORDERS OF THE LOWER BOWEL"
Moderator: *James A. Ferguson, M.D.*, Grand Rapids, Michigan
Participants:
(Gastroenterologist) *H. Marvin Pollard, M.D.*, Ann Arbor, Michigan
(Surgeon) *Robert W. Buxton, M.D.*, Baltimore, Maryland
(Psychiatrist) *H. Keith Fischer, M.D.*, Philadelphia, Pennsylvania
(Pathologist) *Oscar B. Hunter, M.D.*, Washington, D. C.
(Proctologist) *Charles A. Neumeister, M.D.*, Minneapolis, Minnesota

12:30 p.m. *Luncheon and Sections*

Thursday Afternoon, September 26

2:00 p.m. "OPHTHALMOLOGICAL MANIFESTATIONS OF SYSTEMIC DISEASE"
Manuel L. Stillerman, M.D., Chicago, Illinois

2:30 p.m. "MENIERE'S DISEASE"
Wm. H. Wilson, M.D., Denver, Colorado
(Sponsored by grant from Merck Sharp & Dohme Postgraduate Program)

3:00 p.m. *Intermission to View Exhibits*

4:00 p.m. Panel on

"THE PULMONARY INSUFFICIENCIES"

(Co-sponsored by the Michigan Chapter, American College of Chest Physicians)

Moderator: *Geoffrey L. Brinkman, M.D.*, Detroit, Michigan

Participants:

(Internist) *Wm. S. Spicer, Jr., M.D.*, Baltimore, Maryland

(Internist) *Roger S. Mitchell, M.D.*, Denver, Colorado

(Respiratory Physiologist) *Benjamin M. Lewis, M.D.*, Detroit, Michigan

(Radiologist) *Robert P. Barden, M.D.*, Philadelphia, Pennsylvania

Evening State Society Dinner Dance — "MEDICINE MOVES FORWARD" *Edward R. Annis, M.D.*, Florida

Friday Morning, September 27

8:30 a.m. Panel on

"THE PHYSICIAN AND THE DELINQUENT JUVENILE"

Moderator: *Stuart M. Finch, M.D.*, Ann Arbor, Michigan

Participants:

(Pediatrician) *James G. Hughes, M.D.*, Memphis, Tennessee

(Social Scientist) *Raymond Gould, Ph.D.*, Bethesda, Maryland

9:30 a.m. "CURRENT STATUS OF IMMUNIZATION AGAINST VIRUS DISEASE"
Saul Krugman, M.D., New York City

(Sponsored by grant from Merck Sharp & Dohme Postgraduate Program)

10:00 a.m. *Intermission to View Exhibits*

11:00 a.m. Panel on

"IATROGENIC SYNDROMES"

Moderator: *George H. Lowrey, M.D.*, Ann Arbor, Michigan

Participants:

(Internist) *Edward A. Carr, Jr., M.D.*, Ann Arbor, Michigan

(Dermatologist) *Edward P. Cawley, M.D.*, Charlottesville, Virginia

(Pediatrician) *Paul V. Woolley, M.D.*, Detroit, Michigan



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- reduces inflammation and edema
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- rarely sensitizes

General Indications: Wherever inflammation or infection occurs and is accessible for topical therapy, as in burns, wounds, skin grafts; and plastic proctologic, gynecologic, or general surgical procedures.

Dermatologic Indications: Atopic, contact, stasis, infectious eczematoid, and lichenoid dermatitis; neurodermatitis, eczema, pyoderma; anogenital pruritus; primary dermatoses with or without secondary infection; external otitis.

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

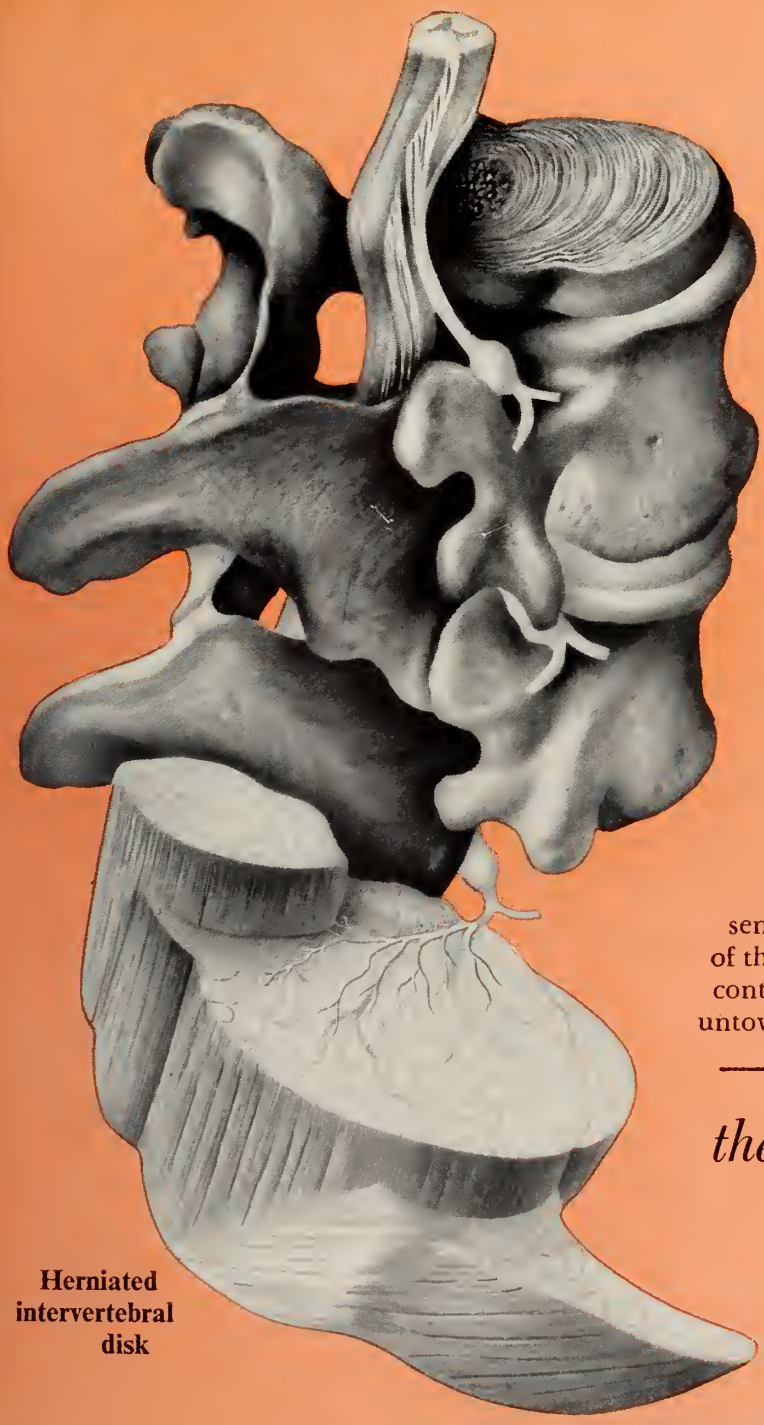
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HIGHLIGHTS of The Council

Meeting of March 15, 1963

Seventy-four items were presented to The Council. Chief in importance were:

- Report of State Health Commissioner re Venereal Disease Reporting: The 1962 House of Delegates request that the rule requiring reporting of certain positive laboratory tests be rescinded was acknowledged; The Commissioner expressed his appreciation for this opportunity to explain the Department's position. The State Health Department and its Council of Health were of the strong conviction that the rule is in the best interests of protecting the public health from dangerous communicable disease and therefore should stand and should be enforced.

- Report on Michigan Medical Service was presented by MMS President Sidney Adler, M.D., of Detroit, who stated that six reports had been sent to members of the Corporation and to The MSMS Council on the rate situation. Actions of the MMS Board and of the Insurance Commissioner, to date, were reviewed. Court hearings are still proceeding in Detroit.

- Public Health Committee, meeting of February 28, 1963. Actions were reviewed by Chairman O. D. Stryker, M.D., of Mount Clemens: (a) Resolution 19 of 1962 House of Delegates (opposing encroachment of public health services upon fields of medicine)—a sub-committee has been appointed to study this matter. The Chairman stated that the main Committee adopted a motion expressing the view that the function or role of State and local health departments described by the November 1962 AMA House of Delegates adequately interprets the functions of state and local health departments. Discussion brought out that the 1962 AMA reversed a previous stand of the AMA. Action on this portion of the Public Health Committee's report was deferred until the Committee could ascertain why AMA's stand was reversed.

 (b) Resolution 8 of 1962 MSMS House of Delegates (evaluation of non-hospital medical care): Chairman Stryker reported that the House of Delegates wished a study of possible means of evaluating the medical care of non-hospitalized patients, either through an existing committee or by formation of a new special committee. The Public Health Committee reviewed its sub-committee recommendations, and raised many questions on how such a study could be implemented, but finally concluded that the Resolution was not feasible.

 (c) Resolution 60 of the 1962 MSMS House of Delegates (consolidation of state health agencies) was also reviewed by Chairman Stryker. In light of adoption of the new Michigan Constitution, other MSMS committees already are involved in this study so no action was taken by The Council on this portion of the report.

 (d) Chairman Stryker's Committee recommended that certain changes be made in the composition and purposes of the Public Health Committee, to improve its future activities, which recommendation was referred by The Council to the Constitution and Bylaws Committee.

 (e) Re establishing chairs of preventive medicine and public health at Michigan medical schools: This item was referred to the MSMS Education Liaison Committee.

- Disaster Medical Care Committee, on February 20, 1963 reviewed the regional disaster care organization and progress in the medical self-help program in Michigan, The Civil Defense Emergency Hospital Training Manual, and the activities of the AMA Disaster Medical Care Committee. In addition, reports were received from the pharmacy and hospital representatives to the MSMS Disaster Medical Care Committee.

- Disaster Medical Care Committee, meeting of April 10, reported on establishment of a task force on medical care in the Michigan Office of Emergency Planning, reviewed the type of regional organization under the task force on medical care, and reviewed medical self-help activities in Michigan. The Committee also reviewed the Hospital Disaster Planning Checklist and heard reports from the nursing, pharmaceutical, military, and Michigan State Police representatives.

- Legal Affairs Committee Nucleus Group meeting of April 4 reviewed items regarding nursing homes in the Medical Aid to the Aged program, program of the Medical Aid to the Aged Conference held in April in Washington, D. C., and Michigan Senate legislation, and recommendations regarding study of reorganization of state government as provided under the new Michigan Constitution.

 The Legal Affairs Committee on May 9 reviewed

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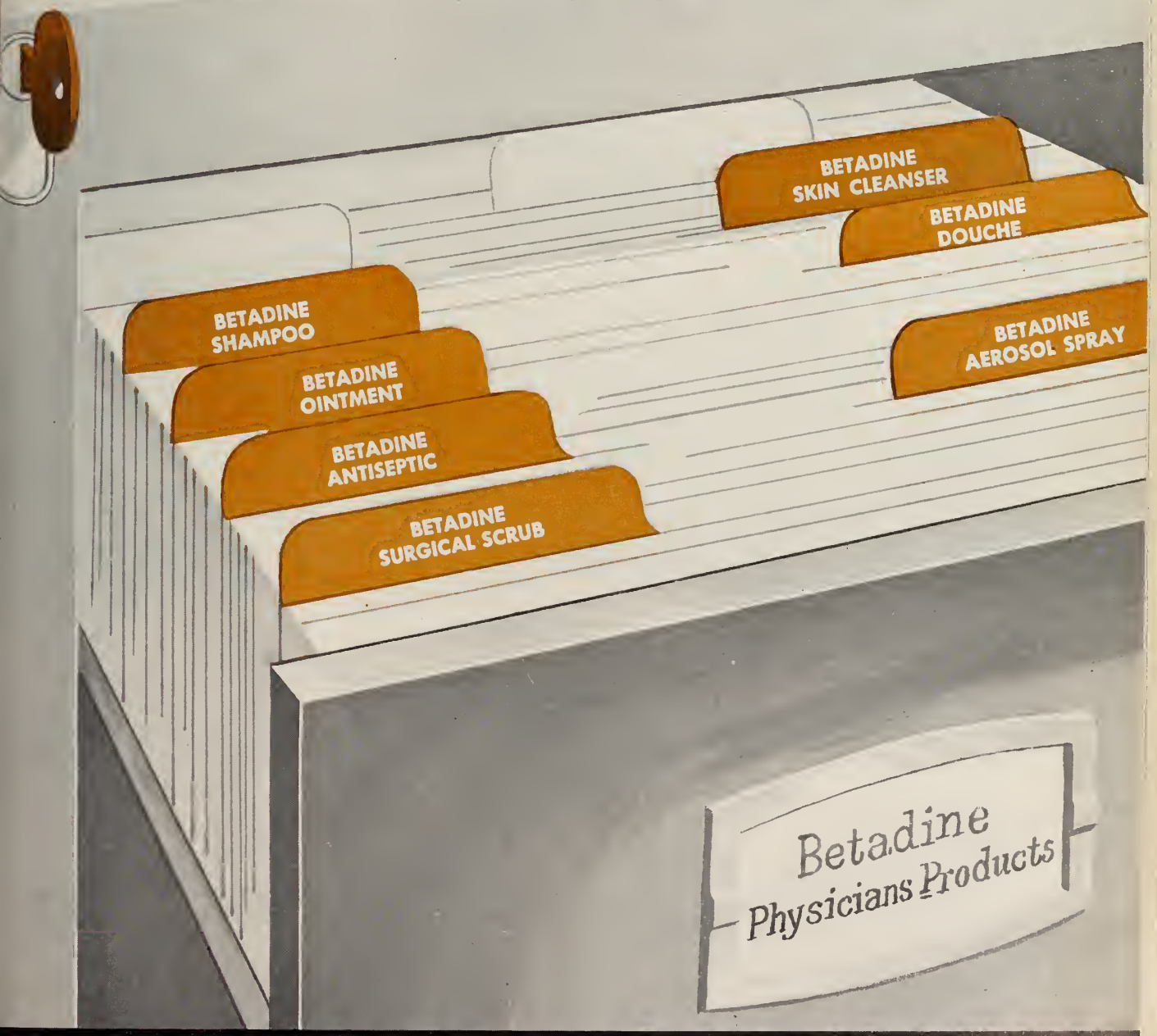
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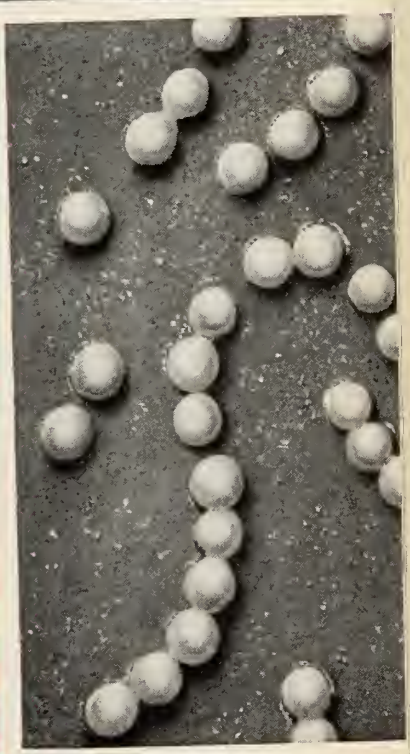
in otitis media, having weighed the classi cal considerations basic to management, physician often choose DECLOMYCIN demethylchlortetra cycline for broad-spectrum antibiotic therapy DECLOMYCIN demethylchlortetracycline produce activity levels higher than do other tetracyclines.. at lower dosage...and maintains them without significant fluctuation.

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Highlights of The Council Meeting

Continued from Page 638

summary of the 1963 State Legislative session, specificially mental health legislation, and Congressional visitations in Washington, D. C. The Committee urged The Council to authorize presentation of testimony on the King Bill before the Congressional Ways and Means Committee provided a successful picture of implementation of Kerr-Mills can be presented for Michigan, which was authorized by The Council. The minutes also outlined progress in seeking a change in Rule 10 of the Michigan Social Welfare Department re fees paid under the Michigan Aid to Aged program. Re reorganization of State government under the new Constitution, the Committee recommended that its proposed eight point program on study planning be approved, which recommendation was authorized to be carried out under the direction of the Legal Affairs Committee.

- Liaison Committee with Michigan State Board of Registration in Medicine, March 15, reviewed the MSMS policy re other schools of healing as well as the Michigan State Board of Registration in Medicine policy, and reviewed intensification of the enforcement of the Michigan Medical Practice Act.

- Geriatrics Committee, March 15, reviewed community programs on aging and participation of local doctors of medicine, the May 1963 JMSMS Number on Geriatrics, and outlined Grand Rapids' pilot project re examination of all applicants for old age assistance.

- Liaison Committee with State Executive Office, April 25, outlined matters of interest discussed with representatives of Michigan Medical Service, and reviewed presentations of facts by MMS management. In discussion, some Councilors suggested that a professional relations program beamed to MSMS members be developed to provide physicians with necessary information to answer subscribers' questions regarding the Blue Shield rate increase.

- Medical Care Insurance Committee, April 11, indicated that this Committee has continued its plan of interviewing representatives of consumers' groups re prepayment medical care and Michigan Medical Service.

- Medical Care Insurance Committee, May 2, reported interview with representatives of the Michigan Farm Bureau and the Michigan Chapter of Health Insurance Council. The Council approved this Committee continuing its personal interviews with representatives of consumer groups and opinion leaders.

- Tuberculosis Control Committee, April 17, discussed the development of a reference card, a report of the State Department of Health, and a report of the Michigan Tuberculosis and Respiratory Disease Association.

- Liaison Committee with State Bar, April 17: The Council had previously approved a proposed Statement of Principles for Hospitals, Lawyers and Doctors with respect to hospital records and contacts between lawyers and patients; at the April 17 meeting, minor word changes were made and the report is now ready for final adoption as recommended by the three organizations represented on the Liaison Committee.

- Mental Health Committee, April 23, reviewed mental health legislation, discussed a proposed meeting of mental health committee chairman of county medical societies, report of representatives from MSMS to recent AMA mental health meeting, the status of federal funds available for planning state mental health programs, the status of the Department of Mental Health under the new Constitution.

 The Council clarified its stand on House Bill 435 of Michigan Legislature: It did not support the abolition of the Mental Health Commission, but moved to improve the principle upon which the Advisory Commission was established.

 The Mental Health Committee urged that component societies be requested to establish mental health committees: The Council recommended that this be included in the next County Societies Letter. On federal funds for planning state mental health programs, the Committee's views was endorsed by The Council.

 The Committee's recommendations for the Department of Mental Health under the new Constitution were referred to the Legal Affairs Committee which is responsible for developing a plan of reorganization for state health agencies.

- Publication Committee, April 25, reviewed a progress report re JOURNAL production, report re study of JOURNAL advertising, policies re THE JOURNAL covering scientific content, editorials, production and non-scientific content. The appointment of an associate scientific editor, as recommended by the Publication Committee, was deferred until the July meeting of The Council.

 Wilfrid Haughey, M.D., of Battle Creek was named Editor Emeritus of JMSMS; The Council commended Doctor Haughey for his years of service to THE JOURNAL and to Michigan Medicine and instructed that a scroll be prepared, signed by the Officers of the Society, and presented to Doctor Haughey whose advice in future planning of THE JOURNAL was requested.

- Rehabilitation Committee, May 1, reported on prog-

(Turn to Page 644)



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Highlights of The Council Meeting

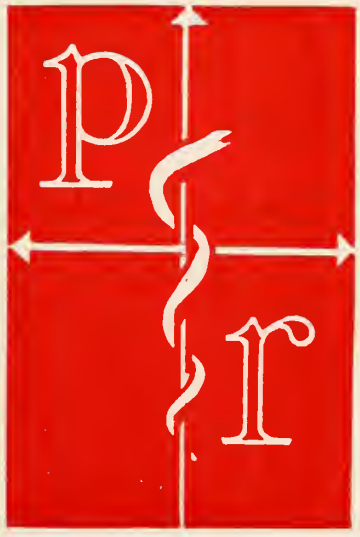
(Continued from Page 642)

ress of plans to survey rehabilitation facilities and services in Michigan, and on rehabilitation activities of the Division of Chronic Disease, Michigan Department of Health, and reviewed the activities of the Division of Vocational Rehabilitation. The Council re-referred to the Rehabilitation Committee the item regarding training program of physical therapists at a certain college of the State.

- Liaison Committee with Michigan State Pharmaceutical Association on May 1 reviewed the proposed inter-professional code of understanding between physicians and pharmacists, and discussed drug vending machines. The Council approved the Committee's recommendation re formation of liaison committees at the component society level.
- Child Welfare Committee, May 8, reviewed the training program for camp health directors, the matter of wrestling weights, the report of the ophthalmological sub-committee, immunization status, and hospital perinatal care. The Committee's request for scientific exhibit space at the MSMS Annual Session was referred to the Committee on Scientific Exhibits.
- President C. I. Owen, M.D., reported that Wayne County Medical Society had designated June as "immunization month" and had recommended placards for doctors' offices. The Council approved expenditure for printing these office placards.
- The Council approved the sponsorship of reception for the Michigan Public Health Officers on the occasion of their August meeting.
- The Council extended an invitation to the American Medical Association to hold its 1969 Clinical Session in Detroit, in conformance with original suggestion of the Wayne County Medical Society.
- President-Elect O. J. Johnson, M.D., of Bay City stated that $14,100 of AMA-ERF funds had been presented to Wayne State University and $21,400 to the University of Michigan.
- The Financial Report to April 30, 1963 and bills payable were approved.
- Appointments and representatives to Meetings: (a) AMA Annual Meeting, Atlantic City: The Speaker, Public Relations Counsel, and Assistant to Executive Director were authorized in addition to AMA Delegates and Alternate Delegates; (b) Seminar for Medical Society Executives, Atlantic City: The Executive Director, as guest lecturer, was authorized to attend. (c) 1963 Training Institute for Organization Management, East Lansing: Staff members authorized to attend were E. Ray Scott, Richard M. Campau. Herbert A. Auer, instructor at the Syracuse Institute, was authorized to attend as advanced student. (d) The Council instructed that a Relative Value Study Committee be established to continue study and review of the Relative Value Scale. (e) Upper Peninsula Medical Society, Sault Ste. Marie: The President and President-Elect were authorized to attend. (f) PCMA Program Committee: Wm. J. Burns, Professional Convention Management Association President, was authorized to attend. (g) Kenneth H. Johnson, M.D., of Lansing was appointed General Chairman of Arrangements for the 1964 Michigan Clinical Institute; Joseph L. Posch, M.D., of Detroit was selected as MCI Program Chairman and D. H. Kaump, M.D., of Ann Arbor as MCI Television Committee Chairman.
- MSMS Group Life Plan: Dividends totaling $30,000 for the year 1962 (approximately 30 per cent of premiums paid) will be distributed on a pro-rata basis to members insured during the past year.
- Executive Director Burns' report stated that 16 meetings of the staff section heads were held to aid communication and develop better methods of handling the work load; weekly meetings of the entire staff were inaugurated May 1, to keep all personnel alert and well informed on current projects and up-to-the-minute procedures; 20 committee meetings were held recently, 19 being covered by staff personnel who also covered 37 other meetings throughout the State (mainly representing liaison work with component societies and information sessions concerning MSMS administrative and legislative activities); 12 State Society Nights were held with some staff section head or a Field Secretary attending every meeting.
- Legal Counsel Lester P. Dodd's report included opinions re consent for postmortem caesarean section; on records of deceased physician; on execution of Blue Cross reverification notice; on anatomy for research; on dispensing of habit-forming drugs directly to patient; on interpretation of Pharmacy Act; on drivers' license of mentally ill; on x-ray film as confidential record; and on medical care of school children without parental consent.
- Public Relations Counsel H. W. Brenneman reported on MAA-Rule 10, on Medical testimony before Michigan Legislative Committees, on Legislative Reports, on AMA Legislative Conference held in Chicago April 20-21, on contacts in Washington, D. C., on Doctor-News media relations, on resolution of PTA urging its local units to seek help of component medical societies to provide medical self-help courses in their communities, on cooperative work of Michigan Health Council and Michigan Association of the Professions, and on support for Saginaw County Fair Exhibit sponsored by Saginaw County Medical Society.

An Editor Looks At Doctors

(Following are excerpts from an address by Martin S. Hayden, Editor of The Detroit News, *before the Harper Hospital Centennial Luncheon, in Detroit, May 3, 1963.)*



I am an editor—and I'm looking at you:

You're a very pleasant sight; even if I didn't know who you are, I'd know by your dress, by your manners, by your conversation, by the handsomeness of your wives, that you are some of the people who make a community tick.

A look around this room and at the cars in the staff parking lot indicates that you do—as a group—get a pretty comfortable living out of our society. But that's good too—you earn it.

As a matter of fact, I think that you earn it—more times over—than do your successful counterparts in other jobs and professions. The public expects more of you:

* * *

FAIRLY OR NOT, THE public expects that he will work at his rounds all day and then go home at night to emerse himself (between telephone calls) in study of the latest medical technics so that, tomorrow if need be, he will be able to use the newest development to meet the problems of another day and another batch of patients.

I wish often as an editor that there was more we could do to report and depict Dr. So-and-so, that real live human, at work preserving the lives of other real live beings. Unfortunately, your codes of ethics inhibit that use of our columns to your public relations advantage. Parenthetically, I think there is too much such inhibition, that your profession should somehow find ways to publicly recognizing and honoring some individual physicians other than the Doctors Kildare and Casey of the TV hospital.

As an editor, I don't hear so much about good old Doc So-in-so, dedicated, beloved by all, guardian in sickness and in health.

Instead, as an editor, I keep running into a public relations monster called "the medical profession." Sometimes it's called the AMA. Sometimes it's called other things, particularly by Democrats and labor union social service directors.

* * *

I USE THE WORD "MONSTER" with malice aforethought—and with recognition of the phenomenon I describe when I try to contend that an assembly of individually fine men can be welded together into something not comparable in quality to its individual parts.

I would submit to you that the advances in the healing art for which we are all so grateful has come, not from the profession, but from doctors, in ones, two or threes. Indeed there is historical basis for a contention that many times roadblocks to the making readily available of new medical discoveries have come from the organized profession, with or without an AMA alias.

I know that the wonderful job done in Harper and other great hospitals is in a great part due to your ability to combine in great or small degree and bring to the individual patient the sum total of the knowledge and ability that can be mustered.

I know too that no profession does more, as a profession, to keep its members abreast of the advancing frontiers of knowledge and experience.

I know that the fine standards to which you hold yourselves and those who would enter your field have been developed over the years by organized doctors acting in concert.

* * *

BUT I KNOW THAT NO professional group has done worse in promoting what it conceives to be its political interests.

I have never been able to figure out why it is that all of you individual, kind, understanding, sympathetic human beings—and I mean that seriously—somehow get transmogrified into a collective monster when you associate for political, and/or public relations purposes.

I have to admit that I do not know how an individual doctor goes about doing something about the things about which I complain. I know, however, that you have a story to tell that is not being told in your behalf. You have an image as individual doctors—a magnificent image of dedication, humanity and professional competence—that is being blurred by mimeograph machines grinding away in Chicago.

In short, your problem is in essence a problem that goes far beyond doctors and into the whole matter of making a democracy work.

* * *

AFTER ALL, THE THEORY we all worship—democracy—says that the nation's problems should be solved by the will and action of an informed people. But then the people—the individual people—too often sit idle and leave the solutions to self-seeking politicians, to pressure group controllers and to the hired advocates of their unions, and their professional societies.

Too few of us will do it ourselves. Too many of us are too wrapped up in the theory of "Kilroyism." Kilroy, you'll remember, was the ubiquitous GI who ran about the whole world writing "Kilroy was here" on any available piece of wall space. He never described "what Kilroy did here."

Individual doctors have got to start "doing something" more to better tell their story and to save their profession.

Advocates Newspapers Increase Science Copy

Watson Davis, director of Science Service, says newspapers should provide "adequate and expert coverage of science and technology. The scientific method applies to everything from stars and atoms to mind motivation. It has created the past and can build the future."

These were statements made at MSU when Mr. Davis delivered the fifth annual Charles Yates Memorial Lecture, sponsored by the Michigan Tuberculosis and Respiratory Disease Association to stimulate interest in the science writing field. He decried that, "Only a very few newspapers cover science and technology as adequately as they do sports."

Smathers, Mills Seek To Equal Care to Aged

Senator George Smathers (D-Fla) and Representative Wilbur Mills (D-Ark.) have introduced legislation intended to provide better medical care for the elderly under federal-state old age assistance programs. Under their bills, states would be required to provide medical care for the indigent equal to the protection given more affluent oldsters under the Kerr-Mills Act.

Senator Smathers has said, "It seems poor policy to provide less in the way of medical care to persons on old-age assistance, who require help with their day-to-day living expenses; than we provide to the recipients of medical assistance for the aged who have enough resources to meet their regular expenses other than medical bills."

Their proposal was part of two programs carrying out President Kennedy's recommendations designed to help the elderly.

Other parts of their "Senior Citizens Public Welfare Amendments of 1963" are: to eliminate the 42-day limit on medical care in a general hospital for persons suffering from mental illness or tuberculosis; to provide that states cannot receive grants for old-age assistance unless they establish and maintain higher standards of health and safety in housing for the elderly; to reduce maximum residence requirement to qualify for eligibility to one year by 1970, and to provide that a third party can receive payments on behalf of a person under the old-age assistance program.

Mills is chairman of the House Ways and Means Committee and Smathers is a high-ranking member of the Senate Finance Committee.

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Each tablet contains methscopolamine nitrate, 2 mg.; and pentobarbital (Warning: May be habit-forming), 8 mg.; plus KANULASE® (cellulase standardized to 9 mg.; combined with pepsin, N.F., 150 mg.; glutamic acid hydrochloride, 200 mg.; pancreatin, N.F., 500 mg.; ox bile extract, 100 mg.).

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Table I—Symptomatic Relief in 25 Patients
(totalling 100 symptoms)

	COMPLETE RELIEF	PARTIAL RELIEF	NO RELIEF	TOTAL SYMPTOMS
KANUMODIC	59	17	24	100
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In a second study, Kanumodic produced "highly gratifying symptomatic relief" in 46 of the 60 patients participating.

Tested in patients over 50*. . . The effectiveness of Kanumodic was matched against placebo response in a study involving twenty-five "over 50 patients" suffering from functional bowel distress. All patients complained of one or more symptoms. A follow-up study of 60 additional cases (average age, 55.3 years) was also conducted.

Proved in patients over 50* . . . The response noted in the pilot study is charted above.

*McHardy, G., and Balart, L.: Curr. Ther. Res. *4*:153, 1962.

Dosage: 1 or 2 tablets, swallowed whole with each meal.

Cautions: Federal law prohibits dispensing without prescription. Side effects such as dryness of mouth, blurring of vision, and urinary retention may occur occasionally with large doses. This product is contraindicated in the presence of glaucoma or prostatic hypertrophy. Glutamic acid hydrochloride is usually not given to patients with peptic ulcer.

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Say you saw it in the Journal of the Michigan State Medical Society

4-H Health Project Started in Branch

The local, state and national medical societies are helping the 4-H Youths in Branch County in a concentrated health program this year.

The following report is from Marvin M. Eppelheimer, Branch County extension agent: "Each 4-H member will maintain one of the AMA 'Your Family Health Record' and will be urged to fill out for each member of their family one of the Michigan Medical cards.

"Each 4-H member will be expected to assemble these items which would add to the comfort and convenience of the convalescent at home. In other words, such things as a box of Kleenex, disposable bag, rubbing alcohol, washable slippers, homemade bed tray for reading and eating, a list of preferred books (for each member of the family).

"Another phase will be the career study with their doctor and nurses in various phases of the nursing profession."



Midland Voters Approve Medical Examiner Plan

The Midland County Medical Society can be proud of a *Midland News* editorial which praised the medical organization for its efforts to bring about a medical examiner system for the county. The editorial, in part, stated: "A tip of the hat is in order for members of the Midland County Medical Society who furnished the leadership to bring about the favorable voter decision on the medical examiner plan. Physicians took the lead in sponsoring the petitions to force a vote on the medical examiner plan. The kind of civic effort on the part of a group best able to provide it represents a deep interest in the community and its problems."

Midland approved a county examiner plan at the April 1 election.

Allegan County Helps Science Fair

The first-place winner in the Southwestern Michigan Regional Science Fair received a handsome plaque from the Allegan County Medical Society. The winner was Janis Sage, Otsego High School sophomore, with her project of a bio-electric cell with organic material.

The Allegan County Medical Society also contributed $100 to the Science Fair project, open to students in Allegan and Van Buren counties.

The plaque was presented by Van O. Keeler, M.D., Otsego.

Van Buren Opposes Cigarettes

The Van Buren County Medical Society is conducting a vigorous campaign against cigarettes. The Society issued a statement, which outlined an eight-point anti-smoking campaign which included urging legislation to stamp cigarettes sold in Michigan with a warning that excessive use is dangerous.

Copies of the Society's resolution were sent to the State Legislature and to other medical societies in other counties.

The Van Buren resolution cited "increasing evidence that cigarette smoking bears a direct relationship to serious and often fatal respiratory disease including pulmonary emphysema, chronic bronchitis and heart disease."

The resolution urged that the "Michigan State Medical Society meeting refuse to allow any form of cigarette advertising in the exhibits as a protest to the unethical methods utilized by these same companies in habituating youngsters."

The Society resolved to purchase anti-smoking literature for distribution to high schools and to contribute up to $100 for an anti-smoking exhibit for the next State Medical Society meeting.

Jackson County Society Holds Career Day

The Jackson County Medical Society sponsored its first annual Medical Career Day recently for 80 seniors from Jackson County high school. Robert E. Medlar, M.D., chairman, arranged for the Foote Hospital event where the program included a tour, speeches and a career recruitment film.



Emergency first aid is demonstrated by Robert E. Medlar, M.D., to three Jackson high school seniors, David Junge, left, and Muriel Keil and Rita Castelein, far right.

Wayne County Elects

Wyman C. C. Cole, Sr., M.D., was selected as president-elect of the Wayne County Medical Society in its spring election. Other 1963-64 officers include Alfred H. Whittaker, M.D., president; Robert K. Whiteley, M.D., secretary; Ralph R. Cooper, M.D., retiring president, five-year trustee, and C. I. Owen, M.D., MSMS president, two-year trustee. Doctor Cole is a member of the MSMS Council, serving as one of the five Councilors from Wayne.

AMA Publication Praises MSMS Legislative Effort

Key medical society leaders across the nation learned about the effective MSMS legislative program in the recent "PR Doctor" publication of the AMA. The AMA publication declared:

"MSMS is implementing its legislative program at the county society level by means of a series of informative legislative reports which are sent to key members of local societies. The reports are mailed at 10-day intervals, and keep members informed on issues of medical significance which are being considered by the Michigan state legislature and by Congress.

"Key-men, representing at least 10 per cent of their society's membership, have been told: 'Extreme vigilance will be required if only those laws are to be passed which will insure the best health care of the people. Your help will not be requested unless it is really needed—but if and when it is needed it will be needed swiftly!

"The Michigan State Society also has provided the county society key-men with Legislative Resource Kits which contain background information on major legislative proposals, including statements of MSMS and AMA legislative policy.

"MSMS has worked hard to encourage Michigan's full utilization of the Kerr-Mills approach to the problems of providing medical care to the needy aged, one of the legislative reports points out. The report states: 'It will be particularly significant if the Kerr-Mills Law can be made to do an outstanding, pacesetting job in the state of Michigan.'

"By taking full advantage of the Kerr-Mills Act, by making the program work throughout the state, Michigan can strike a telling blow to the thesis that (the federal government is the only answer)."

Writer Association Meets

On May 15, the Michigan Section of the American Medical Writers Association had a formal meeting in Ann Arbor, under the new President, Howard Ross, M.D. There was a formal program extending throughout the forenoon. After lunch, Dean Hubbard of the University of Michigan Medical School spoke and then the group adjourned to the medical science building where the program was already in session. Two students presented reports of research work and this was followed by a discussion led by Wilfrid Haughey, M.D., Editor of THE JOURNAL of the Michigan State Medical Society.



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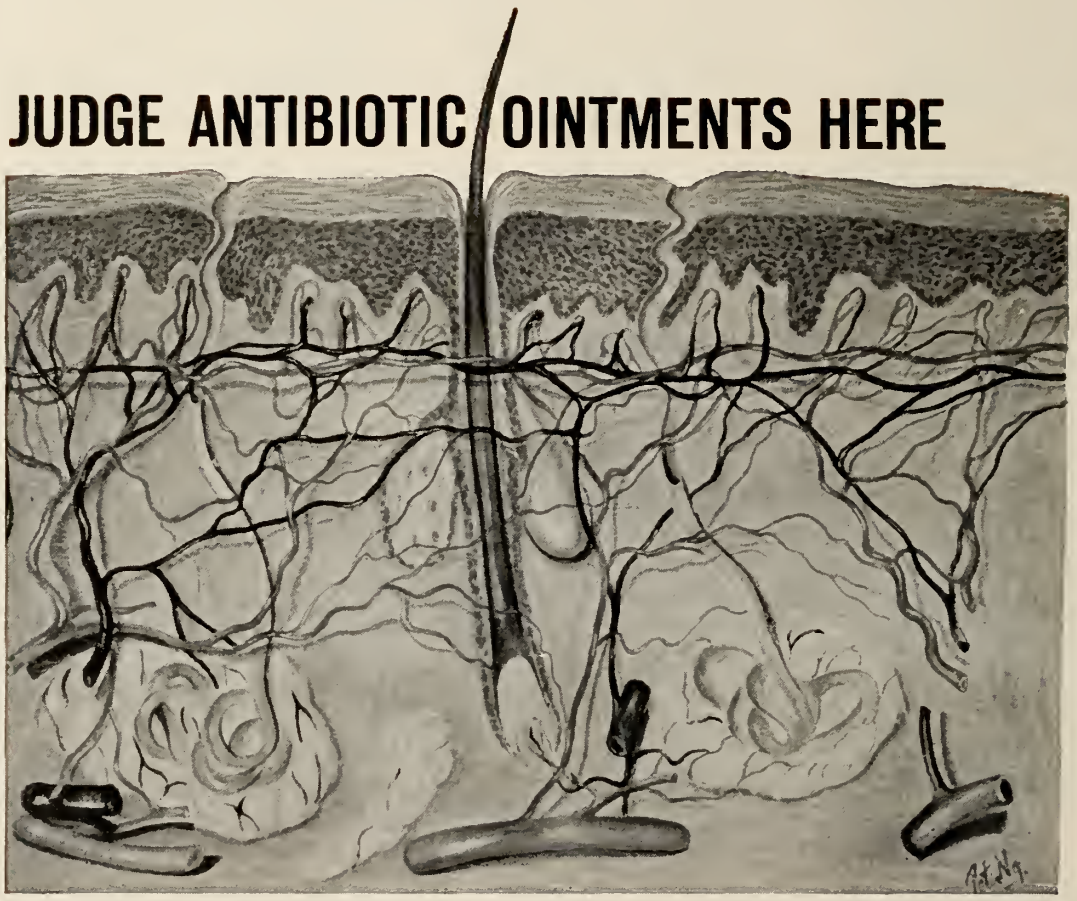
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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

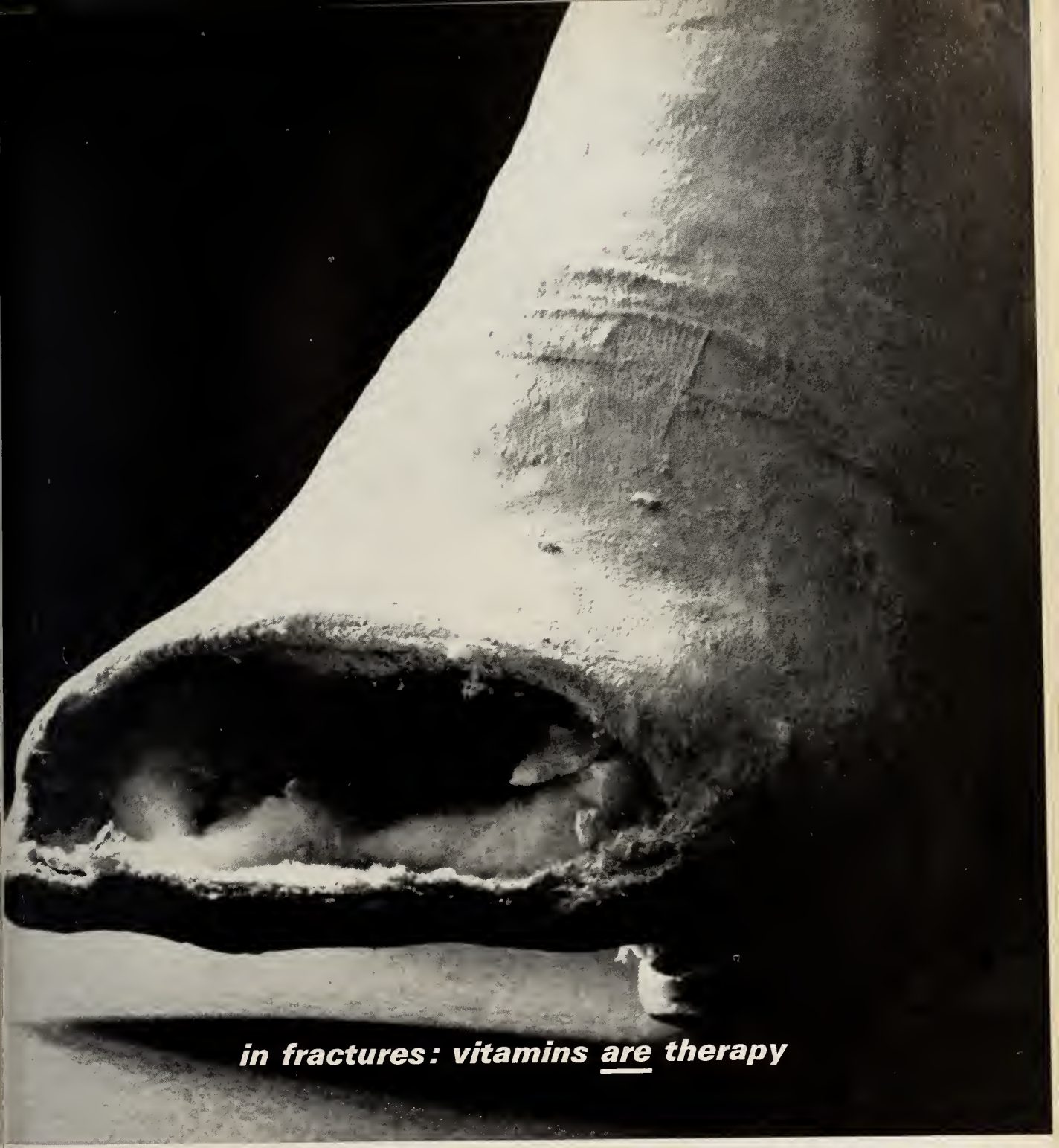
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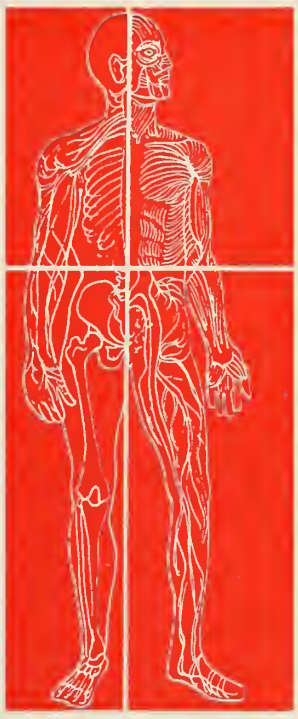
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The Changing Concept of Rheumatoid Disease And Its Management

Richard H. Freyberg, M.D.
New York, New York

IT IS a distinct and unique pleasure for me to be here today and participate in this annual session of the Michigan State Medical Society—unique in that it happens to be the 25th anniversary of the Rackham Arthritis Research Unit in the University Hospital, University of Michigan, in Ann Arbor and the twenty-fifth anniversary of the devotion of my full professional time in the problems of rheumatic diseases. During this time, there has been a constantly increasing interest among physicians and allied research scientists in rheumatic diseases, and there has been literally mushrooming of a large number of rheumatic disease study centers throughout this country. As a result, more investigation in the problems of rheumatic diseases has been conducted during the past quarter of a century than in all the preceding time.

Only a few years prior to the beginning of this quarter century the first organization of doctors interested in rheumatic diseases was formed under the name of The United States Committee for the Study and Prevention of the Rheumatic Diseases. This was made up of only a handful of physicians and surgeons who recognized the great importance of this area of medicine and wanted to start something to be done about it. Fortunately, these pioneers were men of great stature in medicine, and soon, as an outgrowth of this small committee, the American Rheumatism Association was formed. This association has steadily grown, and largely through its efforts has been developed the Arthritis and Rheumatism Foundation, which has been of great assistance in furthering research, public and professional education regarding rheumatic diseases, and increasing and improving care of patients with rheumatic diseases. A great impetus and assistance in this development was the organization of a new institute of arthritis and metabolic diseases in the Public Health Service, which, also, has steadily grown and has provided the great majority of financial assistance making possible the increasing research program. It seems to me particularly appropriate, therefore, today to present a brief review of the developments during this past quarter of a century as they pertain to one of the most important of the





The Author
R. H. FREYBERG
M.D.

From the Department of Rheumatic Diseases, Hospital for Special Surgery, and the Medical Department, Cornell University Medical College, New York Hospital—Cornell Medical Center, New York, New York.

Read at the annual meeting of the Michigan State Medical Society, Detroit, September 26, 1962.

rheumatic diseases. I have, therefore, chosen to discuss the changing concept during the past twenty-five years as to the nature of rheumatoid arthritis (disease) and its management.

At the beginning of our studies in the Rackham Arthritis Research Unit twenty-five years ago, the staff evaluated all of the many problems in the area of rheumatism and chose to make its major interest rheumatoid arthritis. The reseach program was projected in an effort to gain further information that would lead to answers of three important questions: (1) what is rheumatoid arthritis, (2) why is rheumatoid arthritis and (3) what is to be done about it? With the progress of research in the quarter century just ending, these questions have not been satisfactorily answered. However, much information has been gained, which gives us a greater insight into the nature of this disease. There has also been definite improvement in the methods of managing patients with this disease.

Twenty-five years ago, rheumatoid arthritis was considered to be a chronic disease of the joints, the etiology of which was unknown. As research progressed, it has become apparent that this illness is widespread in connective tissue and is one of the diseases commonly referred to as a diffuse connective tissue disease. The designation that I prefer for this is rheumatoid disease rather than rheumatoid arthritis, in order to give the connotation that this is more than a disease of joints but involves much non-articular connective tissue. This, alone, is probably the most important change in concept regarding rheumatoid disease that has come out of the past quarter century.

Rather than consider this illness as one involving the joints only, it is now well known that there is much non-articular connective tissue disorder. In addition to the joint manifestations of this illness, which are characterized, of course, by chronic inflammation (synovitis and capsulitis) and after its presence for a long time, the secondary destructive changes involving the cartilages and the subchondral bone structure, there are many well-recognized non-articular components. These vary greatly from patient to patient. In some instances, they precede the onset of the joint manifestations; in such instances, it is often difficult to be sure of the nature of this illness until the joints become involved. Not infrequently, the patients have stiffness, restriction in motion, manifestations of "fibrocytis," producing much aching and discomfort but without any evidence of true joint structure inflammation. They may have obvious tendon sheath inflammation, bursitis, subcutaneous fibrous nodules for months before arthritis is evident. More important is the fact that after the disease has become established, there is frequently a variety of visceral pathology but having always the characteristics of degenerative changes involving connective tissue structures including collagen, changes in circulation with veniolitis with arteriolitis, with perivascular inflammatory changes sometimes leading to granulomatous pathology typical of the subcutaneous nodule known as the "ear mark of rheumatoid disease." Such changes may occur in the pericardium, myocardium, lungs, pleura, tunics of the eye and the bronchi, perineureum—indeed anywhere there is connective tissue. Hence, it seems justified and correct to consider this a diffuse connective tissue disease rather than a form of arthritis; however, the articular pathology frequently is the most troublesome clinical feature of this illness, so obviously it will continue to be thought of as one of the arthritides.

The change in the concept of the cause of rheumatoid disease during the past twenty-five years has been most interesting. As is true in any situation where definite etiology is not known, a wide variety of theories develop regarding the etiology and pathogenesis. Twenty-five years ago, the many theories of the disease were grouped under four headings: (1) infectious, (2) metabolic, (3) endocrine, and (4) neurogenic.

The name commonly given to this disease twenty-five years ago was chronic non-specific infectious arthritis implying that the major, if not only, cause for this disease was infection. However, all efforts to produce evidence indicating that infection was responsible for the disease failed. Because of metabolic abnormalities present in patients with well-established rheumatoid disease, many different ideas prevailed that one or a combination of these metabolic disorders was the principal basis for the disease. These included disturbances of metabolism of carbohydrates, of minerals, et cetera. Indeed, it is interesting that I was selected from some of the young men on the staff of the Medical Department of the University of Michigan to help get the Rackham Arthritis Research Unit started because it was said I was more familiar with the problem since I had been doing research in calcium and phosphorous metabolism! The abnormalities of endocrine gland function were held responsible in the eyes of a few physicians and, of course, each endocrine gland was accused. The evidence to support such a theory has never been produced.

There were some who believed that the primary abnormality was neurocirculatory, accounting for the obvious abnormalities in the rheumatoid patients effecting the nervous system and the circulation.

During the last twenty-five years, many outgrowths of these major theories at the beginning of the quarter century have evolved. Because infection could not be isolated from inflamed joints, it was believed that infection acted as a focal agent ("focal infection") and that somehow the connective tissue inflammation resulted from a focus of infection. You all know of the "rise and fall" of the focal infection theory. Other ideas were that infection produced toxemia and this caused the illness. Others maintained that there was allergy due to infection provoking this disorder. Toxemia from malabsorption from the intestinal tract was considered. Dietary faults were included in the possibilities. Deficiencies, particularly vitamin deficiency, were popular for a while.

Because rheumatoid disease was frequently seen to become worse when the patients had severe emotional problems or sustained sudden shock with unhappiness, it was considered likely that many, if not all, patients with rheumatoid arthritis had their disease because of psychogenic disturbances, but no substantial support for this evolved. After the work of Selye on stress became well known, for a few years it was quite popular to consider rheumatoid disease as an adductation disease produced by stress and subsequent alteration and endocrine function and the end-organs that the hormones help to regulate. This concept of the disease has few adherents now because of lack of convincing evidence to support this. The study of families of patients with rheumatic disease revealed that there was a higher incidence of rheumatoid disease among relatives of index patients so that the factor of heredity became more in focus and has continued to be considered important in relation to other factors to be discussed later on. Hypersensitivity was reintroduced into the group of different considerations of the cause of rheumatoid disease after studies of plasma protein changes and various serologic reactions of patients' serum linked inflammatory changes that characterize rheumatoid disease with disturbances of immunity.

Among the many studies done in the 1930's in an effort to provide evidence that infection was somehow or other the cause of rheumatoid arthritis as already mentioned, it was observed that certain strains of streptococci would frequently become agglutinated by the serum of patients with rheumatoid arthritis. Although it was first believed that this was some indirect evidence that rheumatoid arthritis was a "streptococcal disease," as the studies progressed it was found that this agglutination reaction was in no way evidence supporting infection as a cause for disease; rather, the agglutination was a result of a reaction of an abnormal macro-globulin present in the plasma of rheumatoid patients and gamma globulin coating the bacterial cells and that a similar reaction would occur with other particles non-bacterial in nature, such as latex or bentonite particles. Similar reaction would occur also with sensitized sheep erythrocytes (coated tannic acid—"tanned"). This reaction was due to affinity of agglutinating factors for human gamma globulin fixed to the tanned cells. These studies soon led to the identification of a macroglobulin or different macrogloblins that were very similar each to the other, which were found frequently in the blood of rheumatoid patients, accounting for this agglutination reaction and, hence, called "the rheumatoid factor." During the last ten years, a great amount of work has been done in many different research centers throughout the world to elucidate the role of the rheumatoid factor in rheumatoid disease. This chapter of research is a very interesting one, and a brief summary here will serve to form the basis for a statement for the present popular concept of rheumatoid disease.

Employing the earlier techniques used for identification of the rheumatoid factor, it was found in the review of a large number of patients studied that 75 to 80 per cent of the patients showed the presence of the rheumatoid factor by agglutination, complement fixation or precipitation tests. But, by these methods, it was important to realize that about 10 per cent of patients severely ill with rhumatoid arthritis in advanced disease failed to react with tests for the rheumatoid factor. The continuing studies showed that approximately 30 per cent of patients that had the syndrome of systemic lupus erythematosis reacted to tests for the rheumatoid factor, also approximately 20 per cent of patients with progressive systemic sclerosis (scleroderma), more than 10 per cent of patients with dermatomyositis, 15 to 20 per cent of patients with different viral or parasitic infections, some patients with sarcoidosis, and 15 to 30 per cent of the patients with chronic hepatitis. Moreover, it was shown in family studies that asymptomatic, non-arthritic relatives of patients with rheumatoid disease gave positive reactions for the rheumatoid factor by latex fixation tests in an incidence up to 20 per cent. These studies lessened the enthusiasm for using

this as a diagnostic test, unless it could be made more sensitive and more specific.

Various means have been employed to increase the sensitivity of the tests for the rheumatoid factor. The use of euglobulin and cold (Swartz) and, also, inhibition produced by dialysis of the serum against buffered citrate solution (Ziff) or the use of euglobulin and ammonium sulfite (NH_4SO_3), all have made the test more sensitive, but these changes have complicated the method and made it extremely difficult to perform except in research laboratories. It has also been shown that using human cells rather than sheep cells in the tanned cell agglutination reaction has significantly increased sensitivity (Vaughn).

The studies of Mellors et al have shown that by a fluorescent technique the identification of the rheumatoid factor in inflamed synovia and/or lymph nodes sometimes is possible when the blood does not react to the usual tests for the rheumatoid factor. It is believed that this indicated that the presence of rheumatoid factor in inflamed tissues exists before the blood concentration is sufficient to identify it in the plasma. This might become a means of earlier diagnosis.

In spite of the hopefulness that identification of the rheumatoid factor might be a practical diagnostic test for rheumatoid disease, up to the present time it has not fulfilled this hope because it is not sufficiently sensitive to identify the rheumatoid factor in all patients. Indeed, if the factor is present in all rheumatoid patients, the appearance of the rheumatoid factor is usually after many months of illness. There are patients without manifestations of rheumatic disease who have rheumatoid factor giving positive tests by latex fixation, et cetera, and the high incidence of healthy individuals who are relatives of patients with rheumatoid disease showing rheumatoid factor as well as the appearance of this in aging individuals who are healthy and without rheumatic disease; all of these factors make this test one that is only helpful but not a dependable diagnostic procedure. Studies of the rheumatoid factor rather than being of practical importance at the present time have led to intense studies as to the disturbance in proteins and disturbance in the immune mechanism in patients ill with this disease.

The rheumatoid factor has been identified as a large globulin (21S); that it is produced in plasma cells where antibodies generally are produced and that it has great chemical similarity, origin and reactivity similar to antibodies. It is thought by most workers to be an anti-gamma globulin antibody. How it is produced is still a puzzle. Some investigators have suggested that various trigger mechanisms such as infections, nervous or metabolic disorders invade the human body and damage connective tissue including synovium, which breaks down to produce antigens, yet unknown, which invoke the production of the gamma-globulin antibody. After this is produced, there then is the antigen antibody complex, which produces the inflammatory reaction characteristic of rheumatoid disease.

The role of the antibody has been investigated by many individuals. Some have thought that it is an important factor in etiology of rheumatoid disease; others that it is the product of the inflammatory reaction produced by the human organism against disease provoked by other means, that the rheumatoid factor is in no way directly concerned with etiology of rheumatoid arthritis is supported by the existence of rheumatoid arthritis for years without identification of rheumatoid factor in some patients. Other individuals who are not sick have significant rheumatoid factor in the blood, giving usual serologic reactions to identify it. A very severe test was produced by Vaughn who transfused blood from rheumatoid patients with high titers of rheumatoid factor into human volunteers and this did not produce rheumatoid disease. Similarly, Levinski injected human volunteers with synovial fluid containing rheumatoid factor and was not successful in producing rheumatoid arthritis. The most difficult situation to explain rheumatoid arthritis as being caused by the rheumatoid factor and its reactions in the body is that many patients with "agammaglobulinemia" or marked hypogammaglobulinemia have classical rheumatoid arthritis with typical subcutaneous nodule formation and, of course, do not have macroglobulin characterized as a rheumatoid factor circulating in the blood. They have practically none of the gammaglobulins and are devoid of most of the well-recognized antibodies. If the rheumatoid factor is an antibody produced by plasma cells and, as the chemistry indicates, a gammaglobulin, how can it be the cause for rheumatoid disease in these agammaglobulinemic individuals? This fact, recently recognized, has swung the interest of investigators to the possibility that if an immune disturbance causes rheumatoid arthritis, it does so by means of cellular immunologic aberrations rather than serological aberrations, depending upon usual circulating antibodies.

Coste has considered the possibility that the presence of large amounts of rheumatoid factor circulating in the body of a patient with rheumatoid disease might alter the nature of the disease by provoking

increased visceral complications. And he postulates that this might be the result of this macroglobulin causing generalized precipitation on the endothelial surfaces of small arterioles and end arteries, producing an endarteritis and a mesarteritis which produces the anatomic and clinical complication of what he terms "connectivitis" features, which are similar to what we recognize usually under the label of "polyarteritis." In this sense, rheumatoid arthritis can be considered a sickness due to hypersensitivity. There has been no evidence to indicate that the rheumatoid factor has been responsible for the inflammation and subsequent pathologic changes at the involved joints.

This leads us to further discussion of the possible role of hypersensitivity to rheumatoid disease. It is known, for instance, that synovitis frequently characterizes serum sickness, and various experimental lesions have been produced in animals by inducing hypersensitivity. Among the pathologic changes are those quite similar to the arthritis of rheumatoid disease and lesions that are similar to human polyarteritis. It has been postulated that human tissues may be altered by toxic products of organisms such as streptococci, producing denatured proteins which sensitize the organ to produce auto-antigens, and these stimulate the production of autoantibodies which are the noxious agents accounting for the connective tissue inflammation characterizing rheumatoid disease. In turn, these lesions of rheumatoid disease, once established, themselves may produce denatured proteins, thus perpetuating the hypersensitivity and accounting for the chronic illness. The hypersensitivity may be immediate, showing usual serologic reactions, high titre of antibodies, et cetera, or it may be delayed, with cellular type of hypersensitivity, such as the tuberculin reaction. There is no experimental support for the concept of rheumatoid disease being an immediate hypersensitivity with serologic features as indicated by the lack of evidence that the rheumatoid factor causes any of the rheumatoid lesions, and by the absence of the rheumatoid factor in some patients with severe and long-standing rheumatoid disease. Most mportant, of course, is the fact that rheumatoid disease occurs in persons with agammaglobulinemia, indicating that the disease does not depend upon the production or the presence of circulating gammaglobulin antibodies.

In support of the cellular or delayed hypersensitivity theory is the observation that early manifestations of the rheumatoid granuloma are initially peri-venous in localization and are similar in this respect to the tuberculin reaction. Lymphocytes and histiocytes are the vectors of this delayed hypersensitivity; plasma cells appear in the granuloma later. It is mentioned by some investigators that the parotitis of Sjogren's disease has the histologic changes characteristic of the cellular or delayed hypersensitivity phenomenon.

Non-rheumatoid illnesses have been recently shown to fulfill all the charactristics of delayed (cellular) hypersensitivity and are thought to be autoallergic diseases. These include encephalitis, thyroiditis, orchitis, sympathetic ophthalmitis. Recently, the work of Hess and Ziff indicates that autosensitive nephrosis is not transmitted by injection of serum but can be produced by the injection of cells from involved animals into other animal recipients.

It must be emphasized that the concept of an illness with autoantibodies does not mean that the illness is produced *by* the autoantibody. Gammaglobulin need not necessarily be the antigen inducing production of antibody such as rheumatoid factor, if this is an antibody. The experimental production of rheumatoid factor in animals immunized with different bacteria and the presence of macroglobulin giving serologic reactions in certain infectious diseases caused by parasites, virus, et cetera—reacting serologically like the rheumatoid factor, does not allow the consideration of the rheumatoid factor as being an autoantibody, but instead, as an abnormal globulin produced as a result of the experimentally induced infection.

Thus there is some suggestion and support for the concept that rheumatoid disease may be a disease of hypersensitivity of the delayed type, but there is much incongruity in the evidence among experimental studies, and by no means any proof for this theory. Now let us investigate another common recent theoretical concept—that is, the immunogenetic theory. That there may be a hereditary immunologic disorder as related to all of the diffuse connective tissue disease is supported by (1) the anatomic, pathologic and clinical features of different diffuse connective tissue diseases overlapping—that is, features of rheumatoid disease co-existing with features of systemic lupus, with Sjogen's syndrome, polyarteritis, et cetera; (2) the presence of abnormal macroglobulins giving serologic reactions characterizing one diffuse connective tissue disease in patients who have clinically another diffuse connective tissue disease, as exemplified by the presence of the rheumatoid factor in many patients who have clinically the characteristics of systemic lupus, in other patients who have had no arthritis but have characteristic Sjogen's syndrome, and the overlapping antinuclear antibody complement fixation reactions; (3) increased incidence of the disease and

serologic reactions of rheumatoid disease and of other diffuse connective tissue diseases in families of index cases.

The hereditary defect may be a multi-factor disorder affecting a group of allied genes, or it may be a biologic abnormality of a single gene. Whichever type of disorder, the abnormal gene or genes produce connective tissue inflammation the variety and expression of which depends on the differences in the tissues selectively involved in each connective tissue disease. How does the genetic defect bring about auto-immunity? One possibility postulated by Ziff if that there is liberation of excessive quantities of normal constituents of a tissue with subsequent abnormal stimulation of a normal immune system, which then produces autoantibodies. A second postulation is that there is emission by altered tissues of denatured proteins (abnormal proteins) which become antigenic and cause the production of autoantibodies. A third possibility is the liberation of normal constituents in regard to both the quality and the quantity, but that there is a deranged immune system which produces autoantibodies. This latter postulate seems more likely and fits with the theory advanced by Burnett that there is a clonal fault inherent in the immunologic system, so that the system does not recognize the normal host tissue protein, considers it a foreign substance and produces autoantibodies to it and thus provokes illness on the basis of autoimmunity, hereditarily conditioned through defects in genes.

Lastly, there is the non-immunologic hypothesis for etiology of rheumatoid disease, which postulates that the reactions in rheumatoid disease are really not immunologic; that these are protein reactions without antigen-antibody participation. It has been pointed out that complement plays no part in the activity of the rheumatoid factor, and recent work by Heimer and his associates indicates that there is in the blood of patients with rheumatoid disease, more frequently and in larger quantities than in other persons, a macroglobulin different from the rheumatoid factor which inhibits complement activity. Baden suggests that there is a common nuclear anomaly in plasma cells synthesizing gammaglobulin; this anomaly may be transmitted by heredity or it may be acquired—but however present, it is thought that this anomaly produces globulins capable of fixing onto connective tissue and provoking an inflammation there. Others (Ziff) consider that such an anomaly, if present, is not hereditary. Experimental work has indicated that plasmacytes may be caused to produce not an antibody but an abnormal and aggressive gammaglobulin which plays no role in cellular hypersensitivity.

Another proposed non-immunologic hypothesis suggests that there is enzymatic degradation of phenylanaline and tyrosine which results in the production of an unusual metabolite—2,5,dihydroxy-phenyl pyruvic acid, which has been found in the urine. It is thought that this substance is disease-provoking.

Through this brief review, it can be seen that most of the consideration of the etiology and pathogenesis of rheumatoid disease during recent years has been along the lines that this disease is one of diffuse connective tissue inflammatory change that results from an alteration of the host tissues and that by some mechanism, not yet understood, whether based on allergy with antigen-antibody reactions, on hypersensitivity of an autoantibody reaction induced by an autoantigen the nature of which is not yet known, or whether it is non-immunologically based tissue alteration and whether it is genetically influenced; for clarification of these questions, much further study is needed and, indeed, is in progress. It may be that relatively soon the pathogenesis of this disease may be clarified.

For some time, I have had a pet concept of the nature of rheumatoid disease and its pathogenesis, which is different from most other concepts in that it does not attempt to explain the disease on the basis of one causative factor but rather is a concept of multiple etiologic and pathogenetic factors. This hypothesis requires that the connective tissue where the pathology of rheumatoid disease exists is a tissue with inherent differences making it susceptible to rheumatic disorders and that this difference or these differences may be and probably are inherited. Let us call this factor A. Factor B is an inherently abnormal or different immune mechanism, which is susceptible to stimuli which may come from various sources causing it to produce abnormal immunologic response and that this immunologic difference may also be inherited or conditioned by hereditary difference. Factor C is an exogenous factor, which acts as a trigger mechanism stimulating the immunologic response causing the reaction in the target tissue, the connective tissue, resulting in the inflammation characteristic of the disease. Such mechanism helps me to explain the existence or lack of existence in rheumatoid disease under what appear to be similar circumstances. Let us consider, for instance, the different possibilities of grouping that would be required to produce the disease. If Factor A and Factor B alone are present,

no connective tissue disease will result. If Factor B and Factor C are present together, no disease will result, but let Factor A and Factor B be present and to this organism Factor C be added, then connective tissue disease of diffuse nature will result. Depending upon the tissues involved and, probably also, upon the immunologic response, the disease will have characteristics that we now place under the labels of rheumatoid disease or systemic lupus or progressive systemic sclerosis, polyarteritis or possibly a combination of two or more of these clinical syndromes. It should be emphasized that I know of no investigations which support this theory and it is theory only.

Having now considered the changing concepts and indicating the current concept of rheumatoid disease, let us consider the way in which management of patients with rheumatoid disease has changed in the last twenty-five years and what is now considered to be by most reliable investigators and clinicians the most scientifically sound treatment based upon the investigations of the past twenty-five years.

Treatment considered proper based upon the con cepts at that time twenty-five years ago have been largely discarded. Thus, no attempts now are made to eliminate infectious disease thought to be present but not understood. Localized infection that formerly was considered the focus and responsible through the focal infection theory for rheumatoid disease is now treated or removed only for purposes of benefit to the sight of the infection locally and for the general health of the patient with full realization that there is little or no likelihood that it will have any direct beneficial effect on rheumatoid process. Treatment with the use of vaccines that was once very popular has now practically disappeared for lack of rationale as well as poor results in trials. Administration of sulfur with the thought that it would make up a sulfur deficiency has been virtually discarded. The administration of large amounts of vitamins such as Hardoses Vitamin D Therapy has been practically discontinued as both theoretically and practically unsound and through the development of the large amount of information concerning rheumatoid disease, the management plan has taken on a much more scientifically sound pattern.

It is now recognized that the treatment for rheumatoid disease is largely management of patient with employment of many different factors well integrated in the management program and changed as the conditions of the disease change and for best results, such a program needs to be patterned individually for each patient according to the pattern of the illness in him. The management program should have very definite objectives. These objectives are as follows:

1. To relieve pain, which is usually the patient's chief complaint.
2. To preserve maximal joint and connective tissue function.
3. To prevent deformities as much as possible.
4. To maintain best general health for the patient.
5. To relieve anxieties and provide most tranquil environment.
6. To correct other co-existing unrelated illness.
7. To arrest or diminish the activity of the disease.
8. To correct deformities if they have occurred and produce maximal rehabilitation after crippling results.

"711 Medical Maxims II"

In males, hematuria as the sole symptom is most likely due to papilloma or carcinoma of the bladder; in women it is more often due to renal calculi or inflammation.

Senile vaginitis may cause bloody spotting.

In prostatic cancer the sternal marrow will show tumor cells in about one-third of the cases.

Urinary infections develop in nearly all patients with indwelling catheters, antibiotics notwithstanding.

Suspect cancer of the bladder in the male with terminal hematuria.

From "711 Medical Maxims II" by W. S. Reveno, M.D.; Charles C Thomas, Publisher, Springfield, Illinois.

Healthy Aging

Edward L. Bortz, M.D.
Philadelphia, Pennsylvania

A RETURN visit to Michigan is always a stimulating experience. Your state is certainly one of the creative germinal centers of our nation. Your scholars for years have been deep in study of the many aspects of this most fascinating of human experiences—the phenomenon of aging. These include the investigation and evaluation of the many changes in body, mind and spirit which are continually going on in you and me and our fellow travelers through our entire lives.

That a condition of uncertainty exists with considerable floundering and probing of false leads is to be expected. For an awareness of aging, what it means, where time is leading all of us opens up new vistas of what life itself is.

It's the stuff of which dreams are made. These changes in ourselves, these aging stigmata and virtues have suddenly taken on a new importance, a more capacious significance. This recent emphasis is the inevitable outcome of the substantial achievements of the scientific method—the sum total of which has completely revolutionized the world in which we are living.

The promise of science is so fascinating and its techniques so intriguing there is a flood-tide of brilliant students entering the laboratories of the physical sciences. When nuclear energy was harnessed a new age in human history was born.

One of our statesmen, Dean Rusk, observes that we are living in a time of rising human expectations.

What has this to do with aging? As a member of the entering class of the medical school immediately after the armistice of the first World War we listened to a welcoming address by Charles W. Eliot, former president of Harvard, then in his eighty-ninth year. He pointed out that the Biological Sciences have more to offer modern man than all the other sciences grouped together. The greatest study of man, so he said, is man himself.

Aging man is much more, or he should be, than a problem of hardening of the arteries, blood pressure, cancer or arthritis. The fact is that medicine's principal concern with the aging individual is his diseases and deteriorations.

Until a re-orientation occurs in the philosophy and objectives of medical education and practice our aging population will continue to live in deficit existence.

Ernest Hooton, anthropologist, wrote in his entertaining book, *Apes, Men and Morons,* the medical profession has a myopic point of view when it starts at the autopsy table and works backwards.

To understand and know the basic important phenomena of aging it is essential to put first things first. Certainly the study of disease and the chemistry of energy pays off. But of equal value and of first priority is to recognize the potentials of healthful growth, development and maturation.

Positive health now becomes a practical objective. Experimentally, as shown by Clive McCay, it is possible to greatly extend the life span of animals. Clinically, therapeutic triumphs are becoming commonplace.

An appreciation of the close relationship between diet, exercise, weight control, posture, motivation and individual well-being gives the physician an excellent plan for promoting health maintenance. Attention to a few simple fundamentals essential for physical fitness may eliminate a vast amount of premature nuisance disorders. On this assumption rests the hope for abundant health in the later years, the golden years of long life.

Is this a visionary mirage? Is it hopelessly Utopian? Such suggestions are referred to by Dubois in his recent book, *The Dreams of Reason* (Columbia University Press, 1961). He writes that Utopias are like holy spirits which give the breath of life to matter. Dreams of reason are the Utopias scientists imagine when they become social-minded.

Each period of life from infancy to age has its own problems, compensations and rewards. We need to relate the various aspects and recognize the feed back mechanism which exists not only between the individual and his environment but also between youth and age and age and youth. Whatever crisis exists for the

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Doctor Bortz is Senior Consultant in Medicine, The Lankenau Hospital, Philadelphia, Pennsylvania.

medical profession regarding the health and medical needs of the elderly requires some candid, hard study. To ignore a major national need is to court disaster. Imagination and bold action with enlightened leadership is desperately indicated.

What should be done? What measures are needed to improve the status of our 17,000,000 aging who are, for the most part, living in a hostile society? At the summit of their years they are too often depressed and frustrated. Their physical infirmities are secondary to the haunting years of encircling gloom. A vigorous stock-taking by the medical profession should be taken. Traditional practice is not enough. Curative medicine, only repair and restoration, is inadequate. It is now time for our profession to come to grips with the depressions precipitated by compulsory retirement. The new diet knowledge for energy support, body fitness plus the vital need for motivation constitute the physician's top recommendations. These reinforcements enhance individual well-being and protect against deterioration.

Experiments

Animal experiments by Clive McCay have shown the possibility of extending life span by restriction of food intake. Clinically, the danger of overweight is established.

Physical performance can be reasonably accurately measured by oxygen consumption, pulse rate, electrocardiograph tracings, blood level of lactic acid, body composition as noted in the studies of Kaare Rodahl and his associates in The Lankenau Hospital. The value of regular exercise to improve body tone, response and general well-being is generally accepted. This basic fact is of first significance in maintaining a solid protection against the flabbiness of body and mind which too often predisposes to ill health. Recently, Dr. Herbert Ratcliffe, Pathologist to the Philadelphia Zoo, informed me that animals kept in good condition by diet, exercise and general precautionay measures usually avoid most of the disturbances of animal life.

An analysis of the complaints of many patients in the upper age brackets indicates the most common to be weakness, vague aches and pains, constipation, insomnia and boredom. These are frequently looked upon as inevitable accompaniments of aging. Examination of the patients uncovers anemias of various types, often due to faulty diets. Likewise, deficient intake of liquids, indifference to adequate kidney and bowel action accelerates the sensation of unhappy aging.

These avoidable conditions obviously aggravate a circulatory lesion and may prove an added burden to some other organic condition which, otherwise, might be well controlled.

This state of affairs which hovers like a threatening storm-cloud over millions of the elderly is rapidly enlarging. The tragic mass waste of knowledge, experience, technical, cultural and philosophical, possessed by large numbers of older individuals, is a national disgrace. At a period in history when our existence as a sovereign power is being challenged, accent on youth (Peace Corps), compulsory retirement and universal down-grading of outstanding teachers and community leaders cannot be too strongly deprecated

Careers for Older Citizens

What better emissaries for presenting the American way of life to undeveloped nations could be found than the men and women of mature years and experience that constitute the top level of our national population? This large group contains many excellent teachers and individuals of wide experience in the various major fields of government, science, education, industry and labor. Since one of the greatest needs in the undeveloped nations is for teachers and counselling in the various down-to-earth activities of daily living, by wealth of experience and much better knowledge of human nature, healthy, mature older citizens are certainly better qualified to render a real service to struggling young nations in the far areas of the shrinking world.

Health is a many splendored phenomenon. Deflections from a healthy state which appear clinically as disease states are receiving exhaustive investigation which ultimately will bring control of the most common disorders. Are the added years to become an extension of positive health, or a prolongation of deterioration of extended dissolution.

The fact that a let down in physical prowess accompanies long life is not too important. With labor-saving machines and automation, the powerful muscleman is less in demand. That we in the upper years take a bit more time to recall a name or an event, that we are somewhat forgetful is not too serious, for in a long and active career myriads of experiences accumulate. To recall one event in old age may take time whereas in youth there is so little to recall. It is a problem of the full, active life and to live such is not a childish task, to quote Pasternack's paraphrase of Macbeth.

There can be a grandeur to age that youth can never know. Many of my most atractive patients, well-groomed, proud and independent, exhibiting the fresh-

ness of the very joy of life have passed their eightieth milestone, and there is an increase in those over ninety.

To re-emphasize, the philosophy that the climax of life, its greatest joys are limited to youth and early years is sheer fraud. The old crocks may contain the finest wines of life. The has-beens may, with the aid of new information about fitness and motivation, out-perform the flabby thirty and forty-year-olds.

These suggestions are all open for study and analysis. Obviously, each life has its end. The philosophy of a youth-oriented culture, oblivious to the opportunities and rewards in later years, has reduced our nation's elders to the unhappy and inexcusable position of second class citizens.

To correct this nation-wide attitude, the oldsters themselves need to regain their second wind. In addition, medicine should recognize its obligation in behalf of our aging population.

Normal vs. Pathological Aging

Old age, the last great epoch of individual human experience, is inevitable for all of us as we escape the hazards of the early and middle years. It is in the natural rhythm and sequence of events. If it is unnatural and unbiological then the later years of human experience, are, *per se*, bad for ourselves and for those around us. There is a huge mass of resentments and ill will in the minds of many older citizens. This unfortunate state, we believe, is due principally to the gross misconceptions regarding the potentials of mature living continued into the extended later years.

Paul D. White[1] writes, "We have paid perhaps undue attention to the harmful effects of fear, sorrow and anger. It is quite certain that biologic effects also result from cheerfulness, optimism, courage and joy." Students of the problem who have thought in some depth find it a rewarding experience to spend more time with our aging patients. It is our obligation to endeavor to prolong the happy state of useful living as the years go by.

Analysis of vital statistics tables indicates that disturbances of the cardiovascular system and cancer (the third being accidents) account for the vast majority of deaths in individuals in the later decades of life. The pathology of old age has been exhaustively documented. No pathologist, however, has ventured to suggest that some particular changes are due to age alone.

Each living species has an approximate life span. The rhythm of growth, development and senescence is the biological timetable by which our lives are controlled. The deleterious impact on living tissues of excesses such as overloading (obesity), inactivity (lack of exercise), prolonged exhaustion (stress syndromes) and general inattention to the simplest elements of wholesome, normal hygiene encourage the changes in the body that are usually regarded as due to age.

Refined scientific procedures now make it possible to greatly extend the life span of experimental animals; also experiments on physical fitness indicate an improvement in body performance and sense of well-being. These findings promise a considerable further extension of the human life span, when our educational system includes the necessary instruction and demonstration of wholesome body care. No one would hazard a definition of what constitutes a healthy state at any age. This is particularly so since medicine, as Hooton observed, has, until recently, considered itself only with disease and tissue deterioration. However, by itemizing the various informants of structure and function it is readily possible to identify the conditions which shorten life.

Healthy aging, we believe, implies a responsive body and nervous system maintained in good running order with a minimum of the depredations that appear as a result of overindulgences, prolonged stress and boredom. Certainly we are all victims of these conditions to a greater or lesser degree, but the emphasis of hope over despair, of a great ideal in living over aimless boredom, of a realization of the enduring values that man holds high when actively pursued gives us our best chance of ultimately finding a peace of mind which is beyond understanding.

Geriatrics is not a narrow special field. It requires a thorough appreciation of the on-going nature of living processes. It necessitates a fresh viewpoint if we as physicians are to render an adequate service. To help our elders we need compassion and understanding and patience; we need to love them so that they may rise to their full potentials. This is not wishful thinking. It is utterly and completely practical. In its finest essence there is in a dedicated service to our older patients, a demonstration that we as physicians know what Albert Schweitzer had in mind when he talked of reverence for life.

Medical science is prolonging life. The quality of the increase is a problem of first importance. In finding ways to improve and sustain high quality of living in these later years we as physicians may find our most satisfying reward.

Institutional Psychiatry and Practice Of General Medicine

Emanuel Tanay, M.D.
Detroit, Michigan

THE PHYSICIAN in general practice is in need of a great deal of information about the old and changing field of institutional psychiatry. In our society, there still persists a remarkable "lack of knowledge" about the function and the role of the public mental hospitals. The average individual has a good concept about the services offered by the general hospitals and in case of the need, he is prepared to accept the services. When we use the expression, "lack of knowledge," we should not be assuming that this is a passive state of being uninformed. The lack of knowledge about mental hospitals is based upon psychological need to remain uninformed. Without recognition of this fact, the history of the care of the mentally ill cannot be understood. As a matter of fact, the most striking feature of the operation of mental hospitals is the fact that the well known and established principles are not put into operation. I shall not go into the reasons responsible for this situation; I am calling your attention to this fact for a specific purpose.

Inasmuch as the general public is so singularly uninformed about mental hospitals, the average citizen will be completely unprepared to deal with this problem in case of need. When mental illness occurs, frequently the general physician will be called upon to interpret the whole complex field of institutional psychiatry. Furthermore, he will frequently take on an active role in the interaction centering around the hospitalization.

The frequency of the involvement of the general physician in these problems can be recognized even through sheer study of statistics.

In 1959, the findings of the Joint Commission on Mental Illness and Health were published. The Commission was established by act of Congress. Survey studies established that one-fifth of the population answered the question, "Have you ever felt you were going to have a mental breakdown?", in the affirmative.

Forty per cent of those interviewed did seek professional help with emotional problems. They went to clergymen, family doctors and psychiatrists in this order of frequency.

On an average day, there are 640,000 people hospitalized with mental disorders. If we include the mentally retarded, this figure rises over 700,000. The admissions per year amount to 430,000 patients, so that the total number of hospitalized patients in a year is 1,070,000.

If you consider that each hospitalized patient affects whole families, then you will appreciate the great numbers of people directly involved in dealing with mental institutions. These people have a variety of questions which they quite naturally will direct to their physicians. The general physician will be approached with these problems because of his medical authority, his position of trust and also because of his availability. There are 150,000 physicians in the United States who are well distributed throughout the country. In contrast, there are ten to fifteen thousand psychiatrists concentrated in large cities. A study by Reginald Robinson revealed that out of 3,103 counties in the continental United States, (excluding Alaska, Hawaii and Puerto Rico) only one-third had a psychiatrist (2,000 counties had no psychiatrists).

The general physician will be involved in all of the stages of hospitalization. We could speak of three distinct periods of hospitalization of a mental patient. The *first period involves the pre-hospitalization stage*, during which one has to deal with a multitude of complicated problems. To name only a few: There is the question of *indications for hospital care*, then there is the issue of reluctance or excessive eagerness on the part of the family to have the patient hospitalized. Questions of prognosis, fears, expectations, etc. Then there is the legal aspect, the commitment papers, issues of competency, etc. Then follows the *intramural stage*. Here, the relatives will confront you with a variety

Doctor Tanay is Director, In-Patient Service, Division of Psychiatry, Detroit Receiving Hospital and Assistant Professor, Department of Psychiatry, Wayne State University, College of Medicine.

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of questions requiring interpretation of the hospital functions. You might be called upon to intervene into the hospital situation or asked to obtain information about the progress of the patient. You might have to deal with a variety of the reactions on the part of the relatives, themselves. Guilt is a common response of close relatives. Various manifestations of anxiety can become apparent. Questions like, "It happened to him; can it happen to me?" "Is it hereditary? Will it affect children, siblings, etc.?" Frequently, we see an irrational denial on the part of relatives. After having requested the hospitalization of the patient, they turn around and say, "He's not sick at all. It is not me who wanted him in a hospital, it's you, the doctor, who has misdiagnosed the case."

Another variety of this response goes something like this: "The hospital does not understand him, hates him, mistreats him, etc." In this connection, I would like to mention a very good study done by Colonel Inwood about Cases of Persistent Hostility to the Hospital on the part of relatives. He demonstrates convincingly that persistent hostility to the hospital is a displacement of the hostility to the patient.

We could concentrate upon the issues of reactions to hospitalization and would end up with an abbreviated psychology of human nature. I feel that the physician has to understand not only the individuals involved, but also the hospital as such.

There is a remarkable lack of information even in the scientific literature on the hospitals, themselves. The mental hospital represents a special sub-culture and should be studied as such. It is truly remarkable that we have an expensive chain of institutions into which we pour millions and millions of dollars and yet we don't subject it to scientific scrutiny. We carry on the functions of running these institutions without the benefit of the knowledge of their "physiology" and even "anatomy." The state hospital is treated like an undesirable transient whom we have to meet once in a while but avoid to get to know well.

Let us ask at this point the simple question, "Why are there state hospitals?" The most reasonable answer seems to be, "State hospitals are in existence due to the simple fact that there are mentally ill for whose care society feels obligated." This statement is simple and attractive. Unfortunately, it is historically not true. State hospitals were created as a social expediency under the assumption that they would solve the problem of "lunatics."

In his book, "The Mentally Ill In America," Albert Deutsch points out that the rise of state institutions and the cult of curability are two parallel developments. State institutions were built on fiscal and not humanitarian grounds. The founding fathers of American psychiatry, the original thirteen superintendents, had to promise great savings in taxes to achieve their goal. To gain support, they have perpetuated what Deutsch calls "a white lie" of curability, which culminated in the results reported by Dr. Awl of Ohio State Insane Asylum in 1840. His records show 100% cure. No surprise that he was called "Dr. Cureawl." Needless to say that these results represent statistical and not a psychiatric achievement.

The primary reason for creation of mental hospitals was to remove undesirable individuals from society, maintain them in isolation at low expense to the society.

Let us turn now to another aspect of the mental hospital. Who are the people called by us, patients, mentally ill, psychotics or whatever term one might use? Who should be hospitalized and for what purpose? As physicians, we are used to answer this question with some reference to diagnosis. In other words, could we say that a schizophrenic, a manic depressive, in short, a psychotic, should be admitted, committed, treated, cured and discharged? This situation is by far not so simple. Admission to a mental hospital has less to do with diagnosis of descriptive type and much more to do with the general facts of human existence. For example, tolerance and the needs of the family might be a more important factor than the clinical symptoms. Also, the concept of treatment assumes an entirely different meaning if you see yourself confronted with a lifelong pattern.

A withdrawn, middle-aged man, who led a secluded life with his elderly mother, but worked regularly and was considered to be "well adjusted," finds himself at a loss due to the death of his mother. He stops working, becomes a burden to his siblings, who for the first time recognize that things are not so good. He is taken to a psychiatrist, recognized for what he is, namely, a chronic schizophrenic, and hospitalized. His symptoms have not changed, but his social adjustment and his environment required a new approach. What will happen to this patient in the state hospital? We know from his history that he has been leading an institutional existence even prior to his admission. The state hospital will provide him with an opportunity to go on living his form of adaptation even without his mother. Needless to say, that this is an actual and a very common case history.

I want to stress the fact that chronic mental illness requiring long term institutional care is a problem which is and will be with us for a long time and maybe

forever. There is no form of life or organization which does not produce its own maladaptation. As long as human society recognizes its responsibility to take care of those who are maladapted, there will be a group of people who will require such care. In view of this recognition, we have to think of the mental hospital not only as a hospital in the strict meaning of the term, but as a community where certain people can go on living. I have asked once a regressed hebephrenic patient why he was in the hospital. He answered in a slow, monotonous, but penetrating voice, "I came to get my mind straightened out and found a place where living was possible." I am stressing this function of the mental hospital because the term "custodial care" has become a dirty word.

Let us speak now of a different situation requiring hospitalization. A young man developed acute psychotic symptomatology with bizarre delusions and hallucinations. The history revealed that he had recently been transferred in his work situation and came in close contact with a few men, whom he at present accuses of suspecting him to be a homosexual. We recognize that the patient was thrown into a state of panic by his own homosexual feelings. In the hospital setting, this patient is given some minimal supportive psychotherapy, makes quickly a social recovery, is discharged within two weeks, to continue treatment on the outside. In spite of his good potential for recovery, this kind of patient frequently becomes transformed into a chronic state hospital patient by the lack of understanding on the part of his physicians. The particular state hospital might be unable to give enough individual attention to recognize his specific conflict. His hospitalization might be the beginning of a long regressive existence.

In summary, then, we can say that hospitalization is precipitated by a failure of adjustment which always is a bilateral problem between the patient and his environment. Most of the patients entering a state hospital are overwhelmed and overpowered by stress of various origins.

Most of the available treatment in psychiatry aims at diminution of stress acting upon an individual at a given time. This is the modus operandi of the drug therapy and supportive psychotherapy. I say advisedly, supportive psychotherapy, to differentiate it from psychoanalysis, which certainly belongs to a different category. Psychoanalysis does not relieve stress, but creates new stress with the goal of reorganizing the personality. This in itself presupposes a strong ego, able to accept frustration and stress for the sake of some future rewards. Psychoanalytic principles are certainly applicable in state hospital psychiatry; psychoanalysis as technique, however, even if available, would rarely be indicated.

The relief of stress in the hospital situation leads in many instances to the disappearance of the symptoms. At this point frequently a misunderstanding arises. The disappearance of symptoms is equated with ability to withstand stress. The relief of stress has restored the equilibrium but it did not necessarily change the capacity to endure stress. In other words, the symptom-free patient is not a cured patient. The point is that a patient who is able to give up his symptoms is not by definition able to return to his environment and face the same stresses originally responsible for his decompensation. I am stressing this point because discharge from the state hospital is frequently demanded on this basis.

In closing, I would like to point to the recent advances in public mental hospitals. There has been an increased awareness that this is a problem which has to be dealt with at a realistic level. The hope that some magical or scientific formula will be devised to solve it once and for all is being slowly and reluctantly given up. Improvements in patient care are continuous. In 1948, the public mental hospitals employed 2135 physicians. This figure has risen by 1957 to 3759, an increase of 76 per cent. At the same time the increase of psychologists amounted to 277 per cent and registered nurses to 90 per cent. In 1959, 51 per cent of all state hospitals had a residency training program approved for three years. The admission rate to state hospitals has been steadily increasing. However, there is a slow decline in the patient population in state hospitals. This by no means should be understood as indicating a trend. There is a popular fantasy that research will lead to empty state hospitals and full state treasuries. The reality is that science holds a promise of better state hospitals but not their elimination. Better state hospitals will not lead to tax savings but to increased expenditures. The great medical discoveries of the last twenty years have not eliminated hospital expenses. On the contrary, in the last ten years the cost of hospitalization in a general hospital has been doubled.

Effect of Erythropoietin in Vitro

Edward R. Powsner, M.D.
Dearborn, Michigan

Lawrence Berman, M.D.
Detroit, Michigan

ERYTHROPOIETIN is the hormone regulating red cell production. A great many reviews of the subject begin by saying that Carnot and Deflandre first demonstrated erythropoietin in 1906, and despite an occasional objection,[1] this statement appears to have become accepted through repetition. It is true that Paul Carnot and Mlle Deflandre[2] postulated the existence of erythropoietin (or hémopoiétine as they called it), but it cannot be said that they succeeded in demonstrating it. Their experiments were reported sketchily. Their results can be described as overly enthusiastic: a rabbit which responded to injections of anemic plasma with a 120 per cent increase in red cell count over three days. That no one has since duplicated this feat is not surprising. Calculation suggests that to have responded to this extent their rabbit would have required the unusually large marrow bones shown in Figure 1. The artist has enlarged only the humerus and femur. There just wasn't room to enlarge anything else. With 5 to 10 times the relative volume of the bones of the rabbits we use, this marrow space must have been jammed with cells ready to respond to erythropoietin in much the way a pernicious anemia patient responds to vitamin B-12.

It seems likely that disbelief in these results of Carnot and Deflandre considerably delayed general acceptance of the existence of erythropoietin. Nevertheless, a few reports continued to appear, some confirming and some apparently denying its existence.[3] Very little appeared in this country for many years. That the existence of erythropoietin was still in doubt as recently as 10 years ago, is reflected in the review by Grant and Root.[3]

It is difficult to be certain how current interest in erythropoietin was stimulated. Borsook, himself an early worker in this field,[1] considered that the contemporary period was initiated by the experiments of

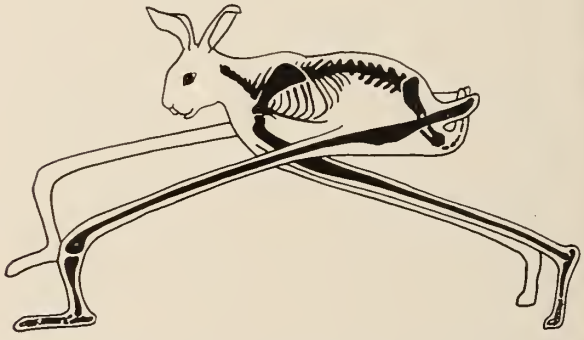


Fig. 1. Artist's version of Carnot and Deflandre's rabbit (see text).

Krumdieck.[4] These experiments are well described and form a reasonably convincing case for the existence of erythropoietin; but, although mentioned in several reviews, they are not referred to in many of the experimental papers of subsequent years,[7-14] a fact which makes their influence difficult to assess. With another viewpoint, Linman and Bethell[5] attribute the revival and acceleration of interest to the work of Bonsdorff and Jalavisto;[6] nevertheless, this work is not entirely convincing. It seems more likely that the current era starts with a group of well described and often quoted experiments which include those of Reissmann[7] demonstrating erythropoietin in parabiotic rats only one of which had been anoxic; those of Grant[3,8] demonstrating transmission of the hormone from anoxic, lactating rats to their non-anoxic sucklings; and those of Erslev[9] and of Hodgson and his associates[10] demonstrating the hormone in anemic rabbits. The experiments of Erslev, for example, were an attempt to

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Doctor Powsner is Associate Professor of Pathology, Wayne State University College of Medicine, and Chief, Radioisotope Service, Veterans Administration Hospital, Dearborn, Michigan.

Doctor Berman is Professor of Hematopathology and Chairman, Department of Pathology, Wayne State University College of Medicine.

repeat those of Carnot and Deflandre. He could not duplicate their phenomenal rise in the red count, but by using large amounts of serum from an anemic rabbit he did succeed in causing a reproducible reticulocytosis in a normal rabbit.

Over the past 10 years, the subject has been explored extensively. The presence of erythropoietin in man was given a firm basis by the classical observations of Stohlman and co-workers[11] who described a patient with hypoxia of the lower body (due to patent ductus arteriosus with right to left shunt) in whom polycythemia was associated with hyperplasia of the marrow, not of the hypoxic iliac crest, but of the normally oxygenated sternum. Significant advances were made when Gordon's group[12] and Borsook and co-workers[13] showed that erythropoietin was present in a boiled extract of plasma, an extract which, in contrast to plasma, was not antigenic and not species specific, and when Jacobson and his associates demonstrated that Fe^{59} uptake could be used as a convenient and sensitive method for assaying erythropoietin.[14]

There now remains no question that a hormone is present in plasma which is capable of stimulating erythropoiesis. For example, Gurney and his co-workers using rats have reported a 37 per cent increase in red count with an accompanying rise in red cell mass over a period of about four weeks after multiple doses of erythropoietin.[15] This may not be as impressive as the 120 per cent increase in three days reported by Carnot and Deflandre, but it is a real and reproducible increase. Red cell production, after all, is growth, and growth requires time. On the other hand, by using appropriate parameters almost immediate metabolic and cellular response to erythropoietin can be demonstrated: bone marrow changes occur in a few hours, increased iron utilization and reticulocytosis in a day or two.[16] Although no one has yet reported, or as far as we know, attempted to produce polycythemia in humans with erythropoietin, it is worth pointing out that the 37 per cent red cell increase referred to represents a true polycythemia—corresponding to a count of nearly 8 million cells per cubic millimeter in a man whose initial count was a normal 5½ million.

Probably of more immediate concern to the clinical pathologist is the fact that erythropoietin levels are now being measured in normal and diseased individuals. Increases have been demonstrated in some anemic patients[17] and in some patients with polycythemia.[18] For example, a recent report describes a tumor in a patient with polycythemia and increased plasma erythropoietin. Removal of the tumor resulted in a cure of the polycythemia. Extracts of the tumor demonstrated erythropoietic activity.[19] Although not yet a procedure for the clinical laboratory, it seems obvious that measurement of serum erythropoietin levels will become a necessary part of the differential diagnosis of many red cell abnormalities ranging from anemia to polycythemia.

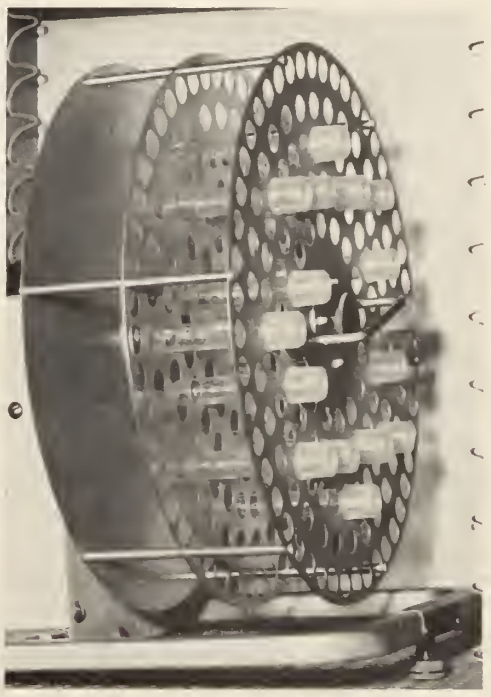


Fig. 2. Culture tubes in roller rack ready for incubation.

Concurrent with these developments in assay procedures, others[26-29] have developed methods for concentrating erythropoietin many fold. Despite this, it has not yet been possible to isolate erythropoietin in even approximately pure form, nor to determine its structure. Many other problems remain; for example, the site of production is far from conclusively identified and in recent conflicting reports,[20,21] the kidney has been ruled both in and out.

Another of the major problems and one of great interest to us is the mode of action of erythropoietin. Very briefly, there is evidence[22] that the effect of erythropoietin is to stimulate the stem cell to increased erythroblast production. Attempts to identify the mode of action more precisely are complicated by the numerous organ and cellular interactions so typical of hormonal action in the intact animal. It has been with this problem in mind that we have pursued our present *in vitro* experiments.

Methods

The *in vitro* culture system has been described previously.[23] The method of obtaining human bone marrow for these studies differs from the familiar technic in that both needles and syringes are rinsed with heparin and the aspirate is handled aseptically. Multiple sites in both sternum and iliac crest are

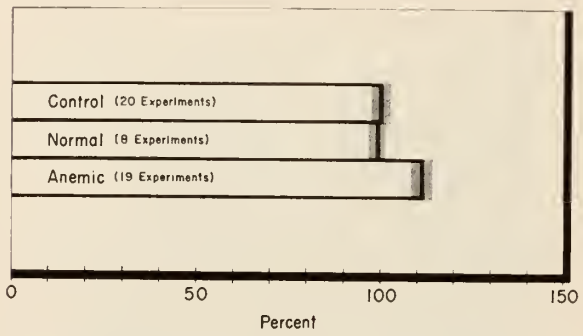


Fig. 3. The effect of extracts of normal and anemic animal plasma on heme synthesis by normal human erythroblasts in vitro. Extracts were kindly provided by Dr. W. F. White and by Doctors Keighley, Lowy, and Borsook. In this and subsequent figures, the length of the bars represents mean C^{14}-hemin radioactivity and the shaded area represents one standard error of the mean, both expressed as percent of the value in control cultures.

required. The method for obtaining rabbit marrow will be described separately.[24] Figure 2 shows the apparatus and roller tubes in which the sterile bone marrow is incubated with autologous plasma, balanced salt solution and carbon-14-glycine. To these are added the test erythropoietic substances which were kindly provided by a number of investigators. To control cultures is added saline. After incubation in roller tubes, heme synthesis, that is, C-14-hemin radioactivity, is measured as previously described.[25]

Results

Results of these experiments showed that in the presence of all but one set of erythropoietic extracts there was a significant, small increase in the amount of heme synthesized. With human marrow this increase, ranging up to 14 per cent more than the control value, was noted in nearly every experiment.

Two groups of investigators were able to provide extracts prepared in similar manner from both normal and anemic animals. Figure 3 summarizes all experiments performed with extracts for which both active and inactive materials were available.* It can be seen that there is a distinct increase in hemin specific activity in the presence of the extracts from anemic animals. This increase is not seen in the presence of the extract from normal animals. Similar results were obtained from other extracts of anemic plasma provided by Drs. W. A. Rambach and H. L. Alt,[28] and by Drs. L. O. Jacobson, E. Goldwasser and J. B. Lesh.[29] Negative results were obtained with an extract of urine provided by Drs. A. S. Gordon and J. W. Winkert,[30] which appeared to contain a contaminating inhibitory substance from urine.

For comparison with these data on the effect of erythropoietic extracts on human bone marrow, Figure 4 shows the results of six experiments with normal human erythroblasts incubated with plasma from severely anemic thalassemia patients. Although the stimulatory effect of anemic plasma has been observed less consistently than that of the more concentrated preparations, on the average an increase in heme synthesis

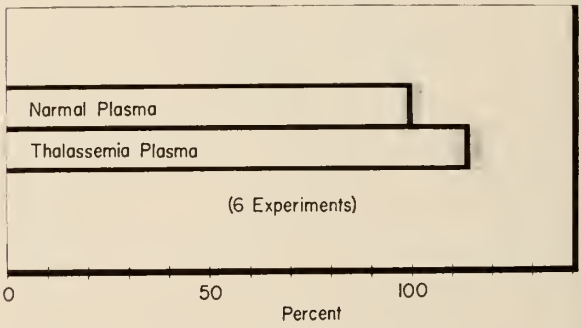


Fig. 4. The effect of untreated plasma from severely anemic thalassemia patients on heme synthesis by normal human erythroblasts. These patients were kindly made available to us by Drs. W. Zuelzer and R. Rosen at the Children's Hospital of Michigan.

is also present. From these results it may be seen that the addition of active erythropoietic extracts of plasma resulted in an increase in heme synthesis, an effect which was also produced from plasma from severely anemic thalassemia patients.

The work so far described has been performed entirely with normal human erythoblasts. More recently, we have started to use rabbit marrow. These results must be regarded as preliminary but they suggest that the effect on heme synthesis *in vitro* may be even greater than that with human marrow.

This first series of experiments is shown in Figure 5. It can be seen that in most experiments there was a decided increase in heme synthesis. This ranges up to 170 per cent of the control, an increase at least three times that obtained with human marrow. In this series

*Extracts from normal and anemic sheep were kindly provided by Dr. Wilfred White.[26] Extracts from normal and anemic rabbits were kindly provided by Drs. G. Keighley, P. H. Lowy and H. Borsook.[27]

of experiments the material used was the sheep plasma erythropoietin concentrate supplied by Drs. Jacobson, Goldwasser and Lesh.[29] It was employed in a concentration 1/10th that used with human marrow. Despite often marked effect in most experiments, in three there was very little effect. Two of these showed a minimal increase and one a slight decrease in heme synthesis. These results are preliminary and represent data obtained concomitant with the testing of new technics for obtaining marrow. Bacterial contamination was a problem in some of these early cultures and in others coagulation occurred. These points are now being more fully investigated.

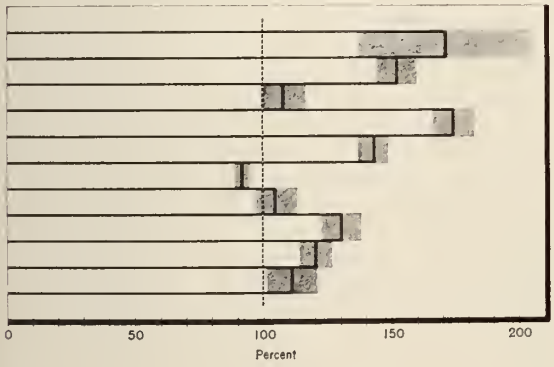


Fig. 5. The effect of an extract of anemic sheep plasma on heme synthesis by normal rabbit erythroblasts in vitro. The extract was kindly provided by Doctors Jacobson, Goldwasser and Lesh. Each bar represents a single experiment.

Additional data obtained in one of these experiments using serial ten-fold dilutions of the active material indicates that the minimum effective concentration in these cultures is .0005 units/ml or .02 μg/ml. This suggests that the rabbit marrow cultures provide a more sensitive test system than do human.

Conclusion

From these *in vitro* experiments, it is clear that there is a material present in plasma and in plasma extracts which stimulates heme synthesis *in vitro*. Because of the obvious simplicity of the test tube compared to the intact animal, it is hoped that study of the *in vitro* model will permit further understanding of the role of erythropoietin in red cell production and regulation and in particular will permit determining how this effect is mediated and how it is related to the *in vivo* effects. Hopefully, this *in vitro* model may also lead to a simplified clinical assay for erythropoietin.

Acknowledgments

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Infection in the Neonatal Period

Henry Gall, M.D., F.A.A.P.
Detroit, Michigan

AN EFFORT has been made to add to our information and observations on the etiology and course of infection in the neonatal period of life. Decisions concerning treatment and control measures may be made easier as a result of this effort. The statistical evidence includes all neonatal births under 28 days of age. The premature and full-term births have been classified separately. Our files were reviewed for all the admissions of full-term neonatal and premature cases to Children's Hospital in Detroit during the period from July 1, 1960 to July 1, 1961. This amounted to 1462 cases of which 484 were premature. A further review of files includes all admissions to the nursery of Lincoln Hospital in Detroit, also during the same period. This amounted to 418 cases with 40 premature infants among them.

As we scan the evidence, it appears that the common bacterial infections of older infants do not occur here, and this has been confirmed by other investigators. Also we are struck by the reporting of many infections with unidentified organisms or with no organisms, and incomplete reporting of pertinent information prior to admission beclouds the picture.

Listed infections in the order of their frequency include pneumonia, septicemia identified by positive blood cultures, diarrhea, pyodermas with or without skin or gland abscess, meningitis, ophthalmia neonatorum, omphalitis, candidiasis and pyelonephritis. Forty per cent of the diagnoses were made without organisms. There were also combinations of infections. As concerns diarrhea, it is possible that bacterial or viral infection may not play a role but still the problems of treatment can be the same. This will be brought out when diarrhea is discussed. One-third of the prematures with infection at Children's Hospital had associated conditions such as hemolytic disease, hyperbilirubinemia and various congenital anomalies. Thirty per cent of the full-term neonates had similar associated conditions. Pneumonia was the most commonly listed infection reported both at Children's and Lincoln Hospitals. There were 87 such cases out of a total of 242 listed infections or combinations, or approximately one-third of the cases. Fifteen per cent of all the full-term neonates and 15 per cent of all the prematures in our 1462 admissions to Children's Hospital had the listed infections as described above. This amounts to 150 per 1000 neonates, well above the figure of 4.3 given by Henderson[1] for major bacterial infections in English maternity hospitals. However, we are lumping together all bacterial infections, major and minor, along with the associated conditions that could very well insure hospitalization. But at Lincoln Hospital during the same period the figure was 5 of 418 births or 1.2 per 1000 neonates. Two of these were premature infants and were transferred to Children's Hospital with pneumonia, candidiasis and Hemophilus influenzae sepsis. The other three were full-term neonatal infants with pneumonia and diarrhea, one of whom had untyped Escherichia coli recovered from the stool.

TABLE I. LISTED INFECTIONS IN NEONATAL ADMISSIONS AT CHILDREN'S HOSPITAL

Infections	Cases	Organisms
Ophthalmia	14	6
Omphalitis	12	10
Meningitis	16	10 (8 pure cases)
Pneumonia	86	44 (60 pure cases)
Pyelonephritis	8	2
Pyoderma	19	11
Candidiasis	11	All
Diarrhea	35	15
Sepsis	36	All
Total	237	145



The Author

HENRY GALL
M.D.

Presented at first of annual meetings of Committee on Welfare of Fetus and Newborn of Michigan Academy of Pediatrics, February 26, 1962.

TABLE II. ADMISSIONS AT CHILDREN'S HOSPITAL

Organisms	Sepsis	Ophthalmia	Omphalitis	Meningitis	Pneumonia	Pyelonephritis	Pyoderma	Diarrhea	Total Cases
Escherichia coli	15	0	1	3	2	2	1	4	28
Streptococcus (B. hemolyticus)	1	0	0	0	0	0	0	0	1
Non-hemolytic staphylococcus albus coagulase negative	4	2	1	0	2	0	0	0	9
Hemolytic staphylococcus aureus coagulase positive	5	3	6	0	1	0	8	0	23
Pseudomonas aeruginosa	1	0	0	0	0	0	0	1	2
Paracolon	1	0	0	0	0	0	0	0	1
Gram positive cocci	1	0	0	0	0	0	0	0	1
Unidentified organisms	6	1	2	5	39	0	2	2	57
Salmonella enteritidis, Manhattan and typhimurium	2	0	0	0	0	0	0	1	3
Bc dysentery (Shigella dysenteriae-Shiga, Shigella sonnei)	0	0	0	0	0	0	0	5	5
Pneumococcus	0	0	0	1	0	0	0	0	1
Listeria monocytogenes	0	0	0	1	0	0	0	0	1
Proteus vulgaris	0	0	0	0	0	0	0	2	2
Total	36	6	10	10	44	2	11	15	134

Adding 11 cases of candidiasis makes the total 145 cases with organisms.

Since Children's Hospital is a pediatric hospital in Detroit, it is likely that infants with the most severe of the listed infections are eventually hospitalized here. Twenty-two per cent of the premature infants with infections and 13 per cent of the full-term neonatal infants with infections died, usually with pneumonia or sepsis given as the cause. The figure for Lincoln Hospital was one out of five (20 per cent), also sepsis responsible. I have no comparable figures from other centers. May I add that in 11 of our 16 premature deaths and in 13 of the 21 full-term neonatal deaths autopsy was performed. The infant from Lincoln Hospital that died was also autopsied.

Pneumonia is the most commonly listed infection in the newborn period, and problems arise here for discussion. Bernstein and Wang[2] last year reported on the pathology of neonatal pneumonia from the autopsy files at Children's Hospital during 1956-1959. Their 55 patients were those who died in the first week of life and were about evenly divided between the premature and full-term infants. We had 13 such cases, four in the premature infants and nine in the full-term infants. Considering our total newborn admissions with listed infections, the division between premature and full-term infants is also about equal. However, three of our autopsied premature infants weighed from 1 pound 12 ounces to 2 pounds 13 ounces. The mortality in the 1 to 2 pound premature infants was 93 per cent and 50 per cent in the 2 to 3 pound premature infants during the survey period. If we add reported sepsis in the small premature deaths and we had four such cases, three due to Escherichia coli and one due to Hemophilus influenzae, all between 2 and 4 pounds, we can say that superimposed pneumonia or sepsis will produce death in the small premature infant. Driscoll and Smith[5] wonder whether the infection produced the premature infant rather than the prematurity favoring the infection. Autopsies in all premature deaths regardless of weight may bring more light to the role of infection in the death of the small premature. The role of the responsible organism in our pneumonia cases agrees with the findings of Bernstein and Wang[2] who state that the infecting organisms can seldom be identified and when they are, are usually customary inhabitants of the intestines. Only 50 per cent of our infants with pneumonia had reported organisms and most of these, about 90 per cent, were not identified. Driscoll and Smith[5] report 33 per cent negative cultures in their cases of neonatal pneumonia. Our identified organisms were Escherichia coli, hemolytic Staphylococcus aureus, and non-hemolytic Staphylococcus albus (Table II). The Escherichia coli and non-hemolytic Staphylococcus albus organisms were recovered in the two premature deaths and two of the full-term neonatal deaths. The other two premature deaths produced unidentified organisms, and the other seven full-term neonatal deaths produced two unidentified organisms and five had no organisms recovered. With pneumonia occurring in one-third of our listed infections and accounting for over 50 per cent of the deaths, it is our major infection headache. Besides, 30 per cent of our pneumonia patients had associated conditions. And with 17 of our 19 pneumonia deaths occurring in the first week of life, this is a critical period for the neonatal infant, especially if associated with prematurity or with related conditions. And when nine of the 13 autopsied deaths have unidentified or no organisms, it makes our problem even more difficult. Because of this, Bernstein and Wang[2] recommend appropriate antibiotics to combat a wide range of bacteria and in full therapeutic dosages. Whether or not viruses are also etiological agents is another debatable point.

The role of the mother as a factor in our infection cases may be of tremendous importance, but sketchy reporting of the obstetrical and antenatal histories does

not enlighten us. Sixty per cent of the patients with premature and full-term neonatal infections had reported no abnormal pregnancies or labors. Bernstein and Wang[2] reported the same difficulties. It is possible that better reporting may reveal an increasingly important role of pregnancy and labor in neonatal sepsis, meningitis and pneumonia. In this connection, the role of infection of the umbilical cord and placenta is still confused, and the popularity of cord sections has decreased. Blanc[3] concludes that the amniotic infection syndrome rarely contributes to overt infection in the newborn and this view is supported by Bernstein and Wang.[2] So that prevention of neonatal sepsis, meningitis and pneumonia by prophylactic therapy is not feasible. However, a truly united effort has yet to be made in spite of extensive studies to date, and a plea is made for a large projected study of this problem.

At this point, let us review our evidence on particular organisms involved in neonatal infections. Since Candidiasis is not a bacterial infection, although a not uncommon offender in neonatal infections, a few words will be said about it in a separate paragraph later. In recent years, much attention has been focused on the important role of the hemolytic Staphylococcus aureus in the nursery and during later periods in the life of the neonate. Our evidence does not substantiate this view. Twenty-three cases of hemolytic Staphylococcus aureus infections, positively identified by cultures and 10 occurring during the first week of life, are reported in a total of 145 infections and combinations with organisms from Children's Hospital. Most of these organisms were recovered in the omphalitis and pyoderma cases (14 cases—Table II). There was one death. Evidently management is simple and effective. There were no reported staphylococcus infections in the three listed infections with organisms from Lincoln Hospital. The only organisms recovered here were Hemophilus influenzae, Escherichia coli and Candida albicans. Only one case of hemolytic Staphylococcus aureus pneumonia with empyema is reported in a 27-day-old full-term neonatal infant. In our series, staphylococcal pneumonia was not a problem of the neonatal period of life. In this connection, I might add that with infection committees operating in many hospitals and on the lookout for hospital acquired staphylococcus infection, the problem has quieted down. It is not now a problem either at Children's or Lincoln Hospital. However, it is still to be emphasized that reporting of staphylococcus cases after discharge from the nursery is very important. The Escherichia coli organism plays a more significant role than does the hemolytic Staphylococcus aureus according to our evidence. Twenty-eight cases of Escherichia coli identified infections are reported; 15 of these giving rise to sepsis, more than half the cases (Table II). Eleven occurred in the first week of life and there were six deaths, four of them in the premature infants. However, three of these premature deaths were in the 2 to 4 pound group, so that mortality in Escherichia coli infection is not just a problem of the infection itself. Nine more cases of Staphylococcus albus coagulase negative infections are reported with one death, and 16 others including Proteus vulgaris, Pseudomonas aeruginosa, Paracolon, beta hemolytic Streptococcus, Shigella dysenteriae (Shiga) and Shigella sonnei, Salmonella enteritidis, Manhattan and typhimurium, and Listeria monocytogenes (Table II). One death with Pseudomonas aeruginosa sepsis is reported. As much as 40 per cent of the infections in the neonatal period had no reported organisms (Table I) and to make matters worse, nearly half of the recovered organisms were unidentified (Table II). At this point, the problem of the introduction of antibiotics before cultures are taken must be emphasized to help untangle the confusion of unidentified organisms. In their series of autopsied neonatal pneumonias Bernstein and Wang[2] advanced the suggestion that the irritating effect of aspirated material or a small inoculum of low virulence bacteria can produce a potentially lethal pneumonia in newborns. This view is supported by Driscoll and Smith.[5] This may also help to explain the confusion of unidentified organisms particularly infection in the first week of life. Bernstein and Wang[2] are therefore correct in not withholding broad spectrum antibiotics regardless of the presence or absence of organisms. But where identified organisms are obtained and presumed to be the causative agents, our sensitivity studies will give the clue to specific antibiotic therapy for effective management.

The problem of the introduction of antibiotics in diarrhea of the neonatal infant until positive stool cultures are obtained is not as important as the problem of dehydration and electrolyte imbalance, even more so, when diarrhea ocurs and no organisms are recovered in the stool. Here the problem may be a viral one or due to feeding difficulties. It is most frequently water and electrolyte imbalance that cause death and not the infection or other underlying causes. Our figures show 35 such cases and without one death (Table I). This is 15 per cent of our total listed infections. Two of our five nursery infections at Lincoln Hospital were diarrhea, in one of which Escherichia coli was recovered from the stool. Both infants sur-

vived. Only four cases of identified Escherichia coli were found among the 35 diarrhea cases in the Children's Hospital statistics and only one was identified as Escherichia coli 026. The other organisms recovered were Shigella dysenteriae (Shiga), Shigella sonnei, Salmonella typhimurium, Proteus vulgaris, and Pseudomonas aeruginosa. There were two cases of unidentified organisms (Table II). Twenty of the diarrhea patients had no organism recovered from the stool, that is over 60 per cent of the cases (Table I). The fact that there was a 100 per cent survival rate in spite of over 60 per cent without identified organisms speaks well for the handling of the problem of dehydration and electrolyte imbalance. This really contributed to our excellent survival rate. Thirty-one of the diarrhea cases (85 per cent) occurred in full-term neonatal infants and over one week of age. Certainly, the problem of diarrhea in our statistics has not been a worry of the nursery at Lincoln Hospital or the premature nursery at Children's Hospital. It is even now not a problem in these two hospitals.

Now a few words about Candidiasis. Our reported cases reveal that Candida infection or thrush is not a significant problem of the first week of life. Only five such cases, all in premature infants, occurred and four during their stay in the premature nursery; this out of a total of 484 premature admissions. These included one transferred from Lincoln Hospital. All survived. There were six other reported cases, both in prematures and full-term neonates, all occurring after the first week of life. It appears, then, that Candidiasis has not been a worry of the premature nursery of Children's Hospital or the nursery of Lincoln Hospital. It is interesting to note that Katz and Kibrick[4] speak of the relationship between vaginal candidiasis of the mother and the colonization and infection of her infant. Also they[4] speak of the rarity of the appearance of Candida albicans infection before six or eight days of life. We can add nothing to these observations.

Summary

In summary we have a statistical survey of all our reported neonatal infections taken from the files of Children's and Lincoln Hospitals during the period July 1, 1960 to July 1, 1961. All the premature and full-term neonatal cases were surveyed. We had a total of 242 infections and combinations out of a population of 1880 neonatal admissions. Pneumonia is at the top of the list as the most common listed infection but, unlike that in the older infants, is caused by organisms considered nonpathogenic for them. In most cases, where organisms were recovered, they were unidentified. This can be related particularly in the first weeks of life to maternal complications, but sketchy reporting of obstetrical and labor histories must be corrected to draw valid conclusions. Also in sepsis and meningitis where organisms are identified, unlike those in the older infant, the organisms turn out to be not so much hemolytic Staphylococcus aureus or hemolytic Streptococcus or Pneumococcus as Escherichia coli and non-hemolytic Staphylococcus albus and other gram-negative bacilli. And the deaths occur here, particularly in the small premature infants where survival is more difficult. The problem of unidentified and no organisms in our reported infections is a major one. Whatever the cause, the introduction of broad spectrum antibiotics whenever a clinical diagnosis of neonatal infection is made and after cultures are taken, is strongly advocated.

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Children's Hospital
5224 St. Antoine,
Detroit 2, Michigan

Lincoln Hospital
1053 25th Street,
Detroit 16, Michigan

Infant Deaths Set New Lows Again

The Health Information Foundation reports that new record lows for the infant mortality rate were established in 1960 and again in 1961—25.7 and 25.3 deaths per 1,000 live births respectively.

As many as one in 10 American babies born in 1915 died before their first birthday. But the proportion is now down to about one in 40, a reduction of nearly 75 per cent. Moreover, the Foundation said, the decline in infant mortality will probably continue.

The greatest advances since World War I have been made against the infective and parasitic diseases, respiratory conditions, and digestive diseases, the Foundation said.

Intestinal Obstruction During Anticoagulant Therapy

Abraham H. Grant, M.D.
Saul Brown, M.D.
Jack H. Kaufman, M.D.
Detroit, Michigan

THE USE of anticoagulant drugs has become widespread in recent years in the treatment of arteriosclerotic and thrombo-embolic disorders. Concurrent with the increased usage of these drugs has been the appearance of hemorrhagic complications. Among these has been intestinal obstruction due to spontaneous intramural small bowel hemorrhage.[1-11] It is our purpose to report two cases in which this unusual complication developed; hemorrhagic involvement of the entire ileum and colon occurred in one, and a jejunal hematoma in the other.

Case Reports

Case 1.—G. W., a 75-year-old male hypertensive patient was admitted October 10, 1953, with his third acute myocardial infarction and was placed on Bishydroxy-coumarin. His prothrombin time was controlled with difficulty due to marked sensitivity to the drug and it ranged as high as 56 seconds. On the fourteenth day after admission, he developed abdominal pain and hematemesis. A flat plate of the abdomen revealed questionable obstruction at the sigmoid colon. At surgery the bowel was discovered to be obstructed at the ileocecal valve by a thickened hemorrhagic segment of ileum. An ileocolostomy was done. The patient died five days after surgery. At necropsy 300 cc. of sanguinous, purulent fluid was found in the peritoneal cavity. Blood was present in the lumen of the ileum and colon and there was hemorrhage of the entire small bowel wall. The colon revealed patchy submucosal hemorrhage as far as the sigmoid colon.

Case 2.—H. J., a 68-year-old white woman, was admitted November 5, 1961. She had been on Bishydroxy-coumarin therapy for basilar artery insufficiency. Three days prior to admission, she developed ecchymoses of the right arm and right breast. Eighteen hours prior to admission, she was awakened by colicky lower abdominal pain. Two hours prior to admission, she had an emesis of a small amount of blood. On admission the blood pressure was 134/80 with a pulse rate of 96. Except for tenderness of the left upper quadrant of the abdomen, no remarkable findings were present except those of the ecchymoses described. The hemoglobin on admission was 13.5 grams per 100 cc. The prothrombin time was over 40 seconds. Vitamin K_1, 50 mg., was given intravenously and a repeat prothrombin time the next morning was 17 seconds.

An upper gastro-intestinal x-ray series done November 6 revealed a large hiatal hernia without ulceration; the stomach and duodenum were otherwise normal in appearance. On small bowel x-ray examination (Figs. 1 and 2) an area of jejunum 7 to 8 cm. in length with tapered ends and picket-fence mucosal pattern was seen. There was partial intestinal obstruction proximal to the involved jejunal area. This was



Figs. 1 and 2.

interpreted as representing either an intramural hematoma producing intestinal obstruction or segmental jejunal infarction. Because it was not possible to exclude segmental infarction of the jejunum, an exploratory laparotomy was performed by Dr. William S. Carpenter 24 hours after admission. A hemorrhagic segment of jejunum, 15 cm. in length, and extending approximately 2 cm. from the ligament of Treitz was found. The hemorrhage extended into the mesentery approximately two-thirds of the distance to its root. The involvement followed the blood vessel distribution and appeared to be pie-shaped. A resection of the involved area of jejunum was performed. The patient's convalescence was uneventful and she was discharged on the twelfth postoperative day.

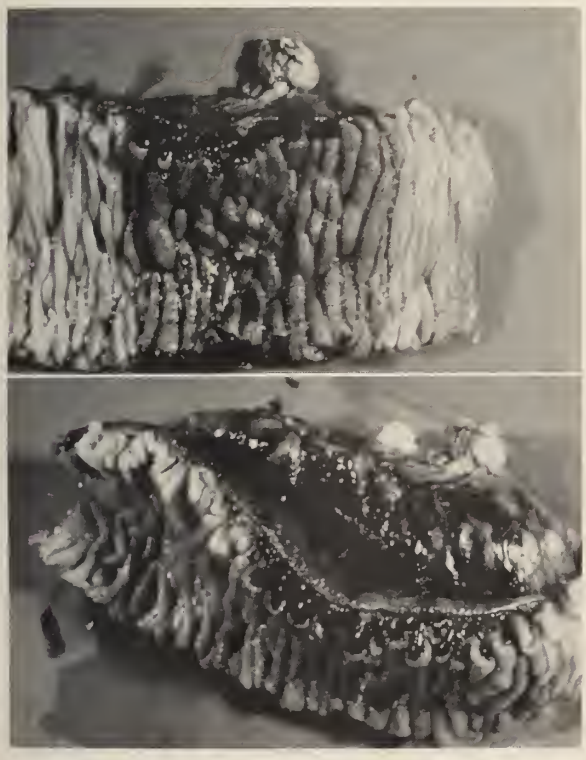
The resected segment of bowel is shown in Figures 3 and 4. In the central portion, there may be seen sharply demarcated 6.5 cm. zone of submucosal hemorrhage. The mucosal folds were thickened, blunted, and elevated by the hematoma with superficial erosion in the central area. The mesentery was hemorrhagic and edematous and there were no areas of

From the Departments of Medicine and Pathology, Sinai Hospital of Detroit.

serosal adhesion nor was there evidence of an organic constriction to account for the unusually sharp demarcation of the lesion. On microscopic examination, the major findings consisted of submucosal hemorrhage with focal mucosal ulceration in the central portion (Fig. 5). The hemorrhage was predominantly perivascular and arose from small vessels and capillaries without evidence of an intrinsic vascular lesion. Although there was beginning organization of the hematoma in the older central portion, most of the hemorrhage was fresh.

Discussion

Among the causes of small bowel obstruction are hernias, adhesive bands, neoplasms, inflammation, and veno-arterial occlusive disorders. A review of the world literature by Spencer et al[1] in 1957, revealed that up to that time 33 cases of intramural hematoma causing intestinal obstruction had been reported; to



Figs. 3 and 4.

these, they added a case of their own. Most of these were the result of trauma and for anatomical reasons occurred in the duodenum. In the past decade an increasing number of case reports citing the relationship between anticoagulant administration and bowel hemorrhage leading to obstruction has appeared. This is largely because more diseases are being considered for this form of treatment and individual case therapy is being carried on for prolonged periods of time.

In most instances of small intestinal hemorrhage due to anticoagulants, bleeding begins intramurally. The blood may dissect into the lumen leading to hematemesis and/or melena or dissect trans-serosally giving signs of peritoneal irritation. A review of the current literature disclosed 18 previously reported cases of intramural hemorrhage resulting from anticoagulant therapy in the last nine years.[1-11] Of these, 10 came to

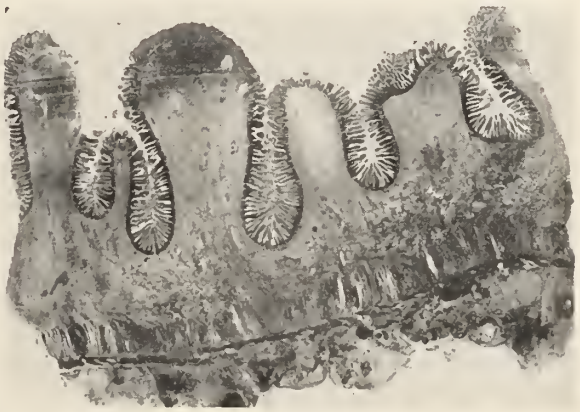


Fig. 5.

surgery. Partial bowel resection of the involved segments was done on seven. Of the total group of 11, only five had barium meal contrast studies confirming the clinical impression of small bowel obstruction.

Intramural intestinal hematoma must be considered in patients presenting with intestinal obstruction while on anticoagulant therapy. If the patient also shows a prolonged prothrombin time, cutaneous or mucous membrane hemorrhages, hematuria, and melena or hematemesis, the possibility of bleeding into the gut wall would be all the more likely. Blood aspirated from the cul-de-sac or by transabdominal puncture affords supporting evidence. When the above clinical picture is correlated with the characteristic barium contrast study findings, the diagnosis of intestinal intramural hemorrhage would seem highly probable.

Senturia et al[6] were the first to describe the roentgenographic picture of intramural hemorrhage of the small bowel associated with anticoagulant therapy, although Felson et al[9] some years earlier, had described the roentgenographic findings in a case of traumatic duodenal hematoma. The classical roentgen findings consist of the appearance of an infiltrating tumor mass in the bowel wall with consequent narrowing of the lumen, and coarsening of the mucosal folds with intervening spike-like projections of barium between them, giving the appearance of an accordion bellows (Fig. 1 and 2).

The decision to explore such a patient surgically

must be individually determined. The risk of surgery is compounded in the face of acute serious disease, as in Case 1, and is relatively small in an otherwise healthy ambulatory patient. There are several instances reported[3,6,8,11] indicating that non-operative management may be undertaken with success. Therefore, the poor operative risk may perhaps be better treated without surgery, whereas surgical exploration is probably the desirable election in the good risk patient in whom intramural bowel bleeding is suspected. Early intervention in such cases is necessary to prevent the development of infarction of the intestinal wall.

If the patient is seen within 24 to 48 hours from the onset of symptoms and the possibility of tumor, mechanical obstruction, or vascular occlusion seems remote, treatment with intestinal decompression by intubation and reversal of prolonged prothrombin time with vitamin K may suffice. If the patient is not seen until 48 hours or more after the onset of symptoms of intestinal obstruction, surgical intervention is probably indicated with minimum delay. Resection of the involved segment should be performed if indicated. In such instances as exemplified by Case 1, where the risk of surgery is excessive, conservative care irrespective of the time of onset of symptoms, is indicated if the diagnosis of intramural intestinal hematoma appears likely.

The gross pathological appearance of the excised segment of bowel in instances where surgery has been done early, reveals a very sharp demarcation between normal and involved bowel. If the coagulation defect is not quickly corrected, the hemorrhagic process spreads and blood may then seek exit into the lumen and/or peritoneal cavity. The muscularis mucosa presents a more effective barrier to the extravasated blood than does the loose outer bowel wall. Case 2 is further confirmation of Felson and Levin's[9] correlation of the anatomic lesion with the radiologic findings. The spikes of barium within the narrowed segment in this case appeared clearly to be the result of hemorrhagic thickening of the valvulae conniventes or plicae. In the more severely involved areas, the space between the swollen plicae is completely obliterated; it is narrowed to a variable degree in the less severely involved areas. Similarly, the hemorrhage, which is predominately submucosal, accounts for the circumferential thickening of the bowel wall and narrowing of the lumen.

The failure of Felson et al[10] to duplicate exactly the radiographic findings by the injection of water into the submucosa in post mortem specimens is probably best explained as a failure to inject water directly into the plicae. The hemorrhage in cases of anticoagulant small intestinal bleeding begins by diapedesis about the smaller, most distal vessels directly within the plicae or valvulae themselves. Hence, the blunting of the mucosal folds, as illustrated in Figure 3, would be the earliest effect, with massive submucosal and mesenteric bleeding occurring secondarily by extension. This concept is borne out by Case 2 in which the central and superficial areas of the plicae were found to be undergoing organization and were mildly inflamed, while the subserosal and mesenteric hemorrhage was quite fresh.

Summary

Two cases of anticoagulant-induced intramural small bowel hemorrhage are reported.

Intestinal obstruction accompanied by prolonged prothrombin time and overt bleeding strongly suggests anticoagulant-induced intramural hematoma.

Management of cases exhibiting this complication is discussed.

Acknowledgment

We are indebted to J. Edward Berk, M.D., Howard H. Feigelson, M.D., Sidney D. Kobernick, M.D., and Arthur S. Shufro, M.D. for their assistance in the preparation of this paper.

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1963 Annual Session Will Be Different

By Harry A. Towsley, M.D., Chairman
Scientific Program Committee
1963 Annual MSMS Scientific Session

The Program Committee is pleased to announce that a new pattern for the 1963 MSMS Annual Scientific Session in Grand Rapids, September 25-26-27, has been developed to pay rich dividends to every MSMS member who participates.

The former Annual Session pattern of a didactic lecture every 30 minutes is being replaced this year by a series of panel discussions by medical clinicians, investigators and educators.

The 1963 program has been arranged to provide broader coverage to specific disease entities common to all physicians—both specialists and generalists. Nationally-known panelists have been obtained to present inter-specialty discussions of timely subjects. The panels will vary from 60 to 90 minutes with ample time for the audience to ask questions.

Program Is Disease Oriented

This new Annual Scientific Session is disease oriented so it will be as practical and helpful as possible. Every doctor in his daily practice needs the very latest information about one or more of the following topics which will comprise the 1963 scientific program:

"Management of the Fertile and Infertile"
"Management of Cardiac Arrest and Arrythmias"
"Cerebral Vascular Accidents"
"Endocrinology of Pregnancy"
"Renal Failures"
"The Physician and the Delinquent Juvenile"
"Disorders of the Lower Bowel"
"Ophthalmological Manifestations of Systemic Disease"
"Ménière's Disease"
"Current Status of Immunization against Virus Disease"
"Iatrogenic Disease"

Further details about the 1963 Annual Scientific Session appear on other pages in this number of THE JOURNAL. Every member will want to consider observing the actions

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of the Annual Meeting of the MSMS House of Delegates, September 22-23-24.

AMA President Annis Will Talk

In addition to the outstanding scientific program and to further highlight the 1963 Annual Session, we are to be honored with the presence of Edward R. Annis, M.D., of Miami, President of the American Medical Association. The dynamic Doctor Annis will deliver the address at the MSMS State Society Dinner Dance at the Grand Rapids Civic Auditorium on Thursday night, September 26.

It is the sincere belief of the Program Committee that this program offers an outstanding opportunity of continuing education in various fields of medical practice.

We sincerely hope YOU will make every effort to attend the 1963 MSMS Annual Scientific Session at Grand Rapids, September 25-26-27 following the 1963 MSMS House of Delegates meeting September 22-23-24.

Seat Belt Effort By MSMS Pays Off

By John R. Rodger, M.D., Chairman,
MSMS Committee on Study of
Prevention of Highway Accidents

The Michigan State Legislature deserves to be applauded for its passage, during the just completed session, of a new law requiring that all new private motor vehicles offered for sale in this state be equipped with seat belts—commencing with January 1, 1965.

MSMS has long officially endorsed the widest possible use of seat belts, as has the American Medical Association which estimated that some 5,000 fatalities could have been prevented last year if the victims had been using these safety devices. The 1961 House of Delegates of MSMS strongly urged every physician to install belts in his personal vehicle as an example.

It must be noted that the new Michigan law, commendable as it is, will not become effective for another eighteen months, a period in which scores if not hundreds of Michigan drivers might avoid death or mutilation by the installation of seatbelts. It must also be noted that the new law requires that belts be installed on *new* vehicles only, and provided only for the driver and one other front seat passenger.

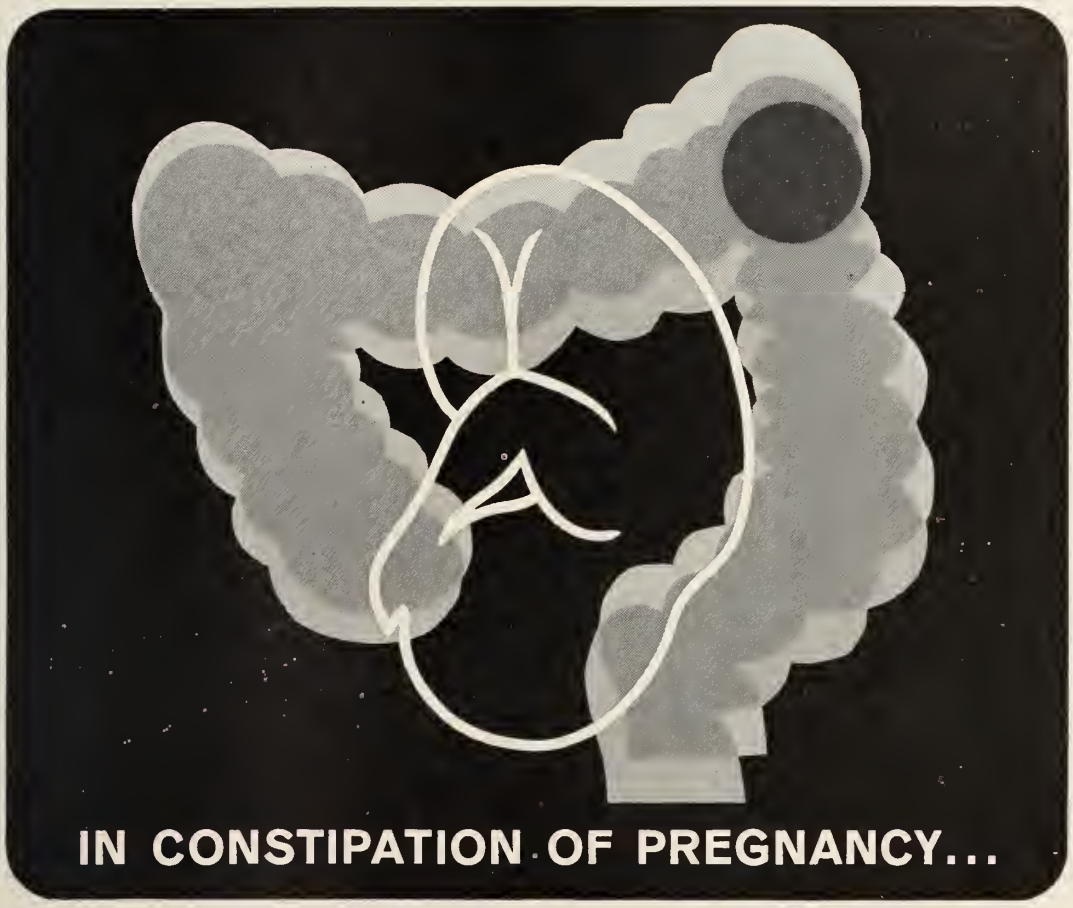
Extensive research proves many points: First, seatbelts have their greatest safety potential in *city* driving, not high-speed highway travel; second, three out of four traffic deaths occur within 25 miles of the victims' homes; and third, *rear* seat belts are extremely important also. A thirty mile per hour impact creates a force of 30 "G's" on an auto's occupants—thirty times the strain of gravity!

Federal law has made it mandatory that all new passenger cars *now* come equipped with properly seated attachments for safety belts. Anyone purchasing an automobile last year, this year or next year can thus easily install these lifesaving devices.

As physicians and healers, it is most fitting that we set the example called for by the 1961 House of Delegates and diligently use seat belts ourselves—whenever we drive—to tangibly demonstrate to as many as we can influence that we are convinced of their value. We should, in fact, also urge others to do so. It can be potent preventative medicine!

Let's not wait until our automobile dealer presents us with seat belts on our 1965 automobile. We might not be around to take delivery anyway—over 5,000 of *this* year's potential customers are no longer on the market. Let's have belts installed right now—both front and rear seats.

(Turn to Page 684)



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Research in the Service of Medicine

Reducing Medical Costs

By Dan E. Reed
Associate Legislative Counsel,
Michigan Farm Bureau

Increasing the supply of doctors is of concern to Farm Bureau members. Any hope for lower costs for medical care must tie in with adequate and available medical personnel.

The American Medical Association is urging doctors to appear at "Career Day" conferences and use other opportunities to encourage qualified young people to take up Medicine. A medical careers kit is available.

AMA points out that 7,500 medical students graduate each year. Double that number will be needed in ten to fifteen years with present population growth and increased medical demands.

Competition for top students by other sciences is making it harder to attract the needed A and B scholars. Today, better than two of every three applicants to a medical school are accepted. Many C students are enrolled. Authorities believe this ratio is dangerous and can lead to lower quality medical care.

Many farm families may have a potential young doctor in high school. He or she may find a satisfying and worth-while career in Medicine, and a better income than many other occupations would provide.

One of the problems has been limited finances. AMA now has a Medical Education Loan Guarantee program which backs bank loans of up to $1,500 per year with low interest rates and repayment after the medical student completes his education. Contact your doctor or AMA—Education and Research Foundation—535 N. Dearborn St., Chicago, Illinois.

A New Form of Segregation

(Excerpts from *Wall Street Journal*)

"Our aged have not been singled out," said President Kennedy, "to segregate them from other citizens."

The words, from his special message on the elderly sound defensive, and well they might. For if the federal government could do more than he proposes to segregate the elderly into a new and pitiable class, it is difficult to see how. Even the term "senior citizen," which Mr. Kennedy uses quite frequently, must grate on an old person's ear; one of those euphemisms like "mortician" favored by people who don't like to speak directly. We are not so young as to be insensitive to the problems of aging, but we don't want anybody calling us a senior citizen as though we were something set apart from our fellow men.

The segregation thread runs through much more than the President's discussion of medicare, though that is an important example. Discounting the tremendous expansion of private and public health care for all people including the aged, Mr. Kennedy dogmatically insists on his compulsory Social Security approach for those over 65. Whether or not it is an opening door to socialized medicine, as it may well be, it is surely about the most costly and inefficient scheme imaginable.

Then consider some of the Government's other plans for putting old people in a special category:

More food and drug protection for the elderly—special tax benefits for the elderly. "Improvement" in general old-age assistance, including Federal intrusion in the private matter of their handling of money. A new five-year program designed to stimulate employment opportunities for the aged—at a time when more and more companies are opening up such opportunities.

There is to be much more housing assistance as well. It would include aid for construction of "specially designed" housing for the elderly (no segregation intended, of course). It would make single old people eligible for "moderate income" housing by which interesting category is meant people whose incomes are too high for public housing but too low for private housing.

Men can debate the merits of any of these and other specific proposals. But take the message as a whole and it is impossible to avoid the unpleasant impression that old people as a class are being treated as incompetents whose only hope is to become wards of Government.

This not only carried the disagreeable political implication of an attempt to turn the growing number of older people into a vested voting interest. It is also something far worse in social terms.



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain... not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

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CSO-9193

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the bronchodilator
with the intermediate dose of KI

A combination of the four most widely used drugs for treatment of asthma. Each tablet contains Aminophylline 130 mg., Ephedrine HCl 16 mg., Phenobarbital 22 mg. (Warning: May be habit forming), Potassium Iodide 195 mg.—compounded for prompt absorption and balanced action, and buffered for tolerance.

Dosage in asthma, emphysema, bronchiectasis, chronic bronchitis: One tablet with a full glass of water, 3 or 4 times a day.

Precautions: The usual precautions for aminophylline-ephedrine-phenobarbital mixtures. Iodides may cause nausea, and very long use may cause goiter. Discontinue if symptoms of iodism develop.

Contraindications of Iodides: Tuberculosis, pregnancy (to protect the fetus against possible depression of thyroid activity).

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The Mudrane GG formula is identical to Mudrane except that Glyceryl Guaiacolate, 100 mg. replaces the Potassium Iodide as the mucolytic-expectorant.

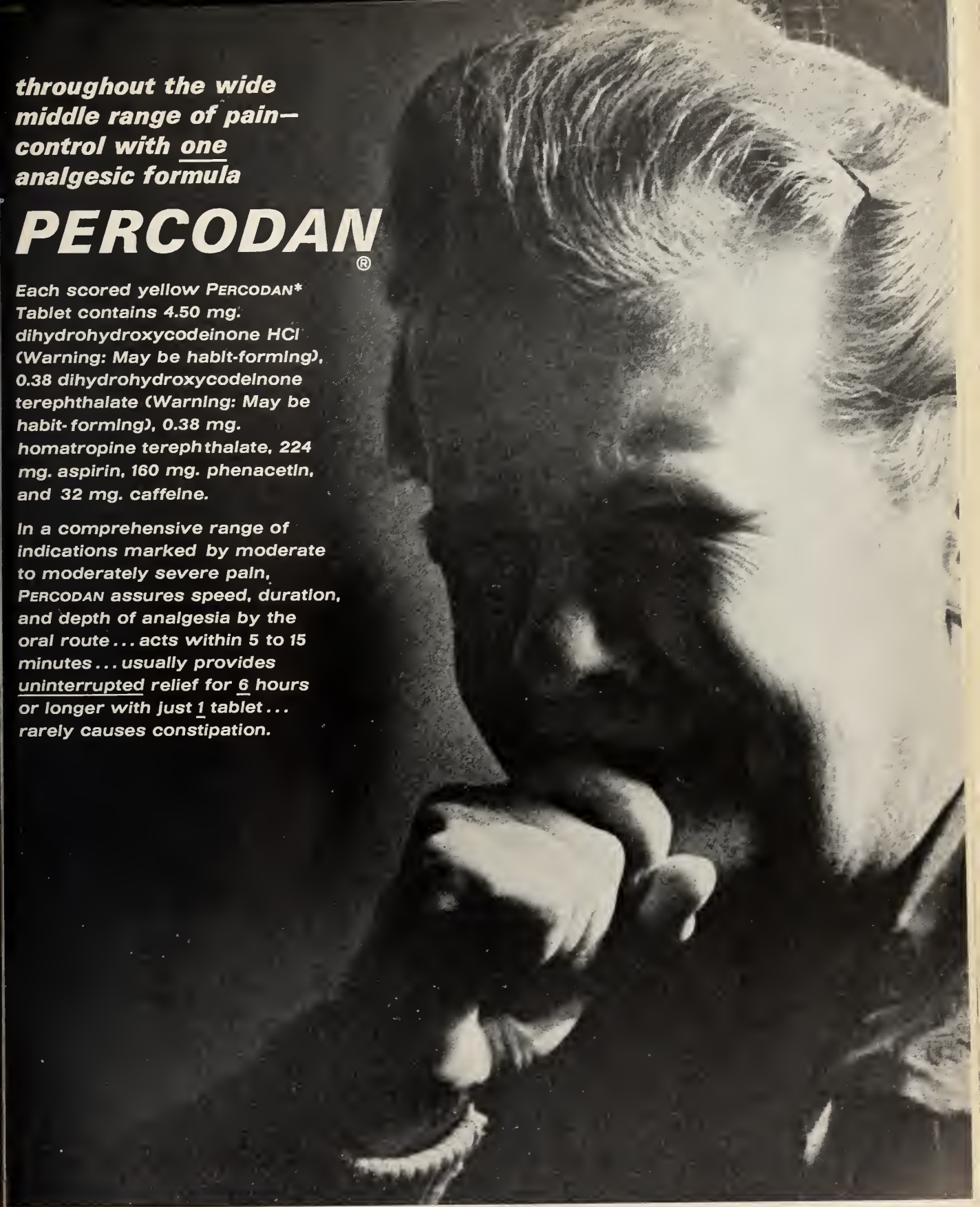
Glyceryl Guaiacolate has no known side effects.

Caution: Federal law prohibits dispensing these products without prescription

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PERCODAN®

Each scored yellow PERCODAN Tablet contains 4.50 mg. dihydrohydroxycodeinone HCl (Warning: May be habit-forming), 0.38 dihydrohydroxycodeinone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.*

In a comprehensive range of indications marked by moderate to moderately severe pain, PERCODAN assures speed, duration, and depth of analgesia by the oral route... acts within 5 to 15 minutes... usually provides uninterrupted relief for 6 hours or longer with just 1 tablet... rarely causes constipation.

Average Adult Dose—1 tablet every 6 hours. **Side Effects and Contraindications**—Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. **Also available:** PERCODAN®-DEMI, containing the complete PERCODAN formula but with only half the amount of salts of dihydrohydroxycodeinone and homatropine. Both products are on oral Rx in all states where laws permit. Narcotic order required. **Literature on request.** ENDO LABORATORIES Richmond Hill 18, New York

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NTz Nasal Spray gives prompt, dependable decongestion of the nasal membranes for fast symptomatic relief of hay fever. The first spray shrinks the turbinates, restores nasal ventilation and stops mouth breathing. The second spray, a few minutes later, improves sinus ventilation and drainage. Excessive rhinorrhea is reduced.

NTz Nasal Spray also provides decongestive relief for head colds, perennial rhinitis and sinusitis. Supplied in leakproof, pocket-size, squeeze bottles of 20 ml. and in bottles of 30 ml. with dropper.

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NTz is more than a simple vasoconstrictor. It contains [N]eo-Synephrine® HCl 0.5%—the efficacy of which is unexcelled—to shrink nasal membranes and provide inner space; [T]henfadil® HCl 0.1% for topical antiallergic action; and [Z]ephiran® Cl 1:5000 (antibacterial wetting agent) to promote the spread of the decongestant components to less accessible nasal areas.

NTz is well tolerated and does not harm respiratory tissues.

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Who Did What to Blue Shield?

By Frank O. Starr

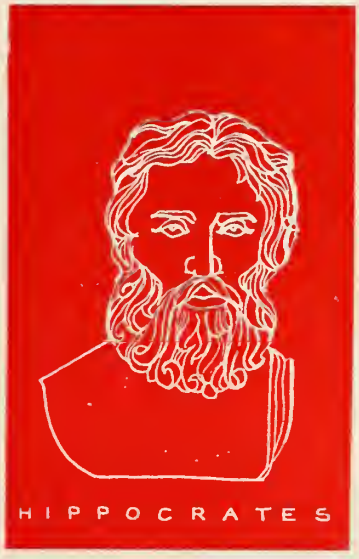
Deputy Executive Director, Michigan Medical Service

Here are the facts surrounding the submission of the Consent Judgment to the Blue Shield Board of Directors.

At the very outset, there must be a complete and unqualified understanding that Blue Shield needed a rate increase to survive—to remain in business.

The Consent Judgment was the instrument which gave Blue Shield this vital rate increase. It is not an arbitrary document suddenly thrown into the lap of the medical profession without warning and cannot be evaluated intelligently without recognizing the position in which the Insurance Commissioner had placed Blue Shield.

Three months of concentrated effort by Blue Shield to obtain rate-increase approval from the Department of Insurance had proven futile. Before he would approve an increase, the Commissioner was demanding changes such as public Board members chosen by the Governor; direct payments to the patients of non-participating doctors with assignments prohibited; joint committees with a series of reports and deadlines, et cetera. Blue Shield felt that these changes would sacrifice basic principles and refused to comply. Finding the Insurance Commissioner still unyielding, Blue Shield instituted its own rate increase, fully aware that this action invited a legal case, the outcome of which would rest in doubt.



MMS Taken to Court

The Insurance Commissioner then took Blue Shield to court, where he yielded to the truth of its financial predicament. Let me make it quite clear that the actions in court by Blue Shield management were based on decisions, influenced on the one hand by Blue Shield's immediate need for money, and on the other by the need to safeguard the basic principles governing the corporation and those of the medical profession.

Blue Shield signed the Consent Judgment on May 15, obtaining its rate increase through arbitration by a Circuit Court Judge. Was this Consent Judgment a violation of Blue Shield's or the medical profession's principles?

Consent Decree Reviewed

Let's review the main points in the Consent Judgment and see what the facts are:

1. Participation of Doctors of Osteopathy: the Board voted for the second time to give them participating status Jan. 9, 1963; Blue Shield has been paying them since 1940.

2. Participation of podiatrists: the Board sought MSMS Council approval for their participation Feb. 4, 1955; Blue Shield has been paying them since 1951.

3. Executive Committee subcommittee meetings with the Insurance Commissioner: the judgment enumerates a specified agenda for discussion—which is no more than that. Recommendations from such meetings must take the normal course through Board channels.

4. Non-Group and Senior Citizen Contracts: plans for reopening these contracts were scheduled earlier this year, to go into effect immediately upon receipt of a Blue Cross-Blue Shield rate determination.

5. Board membership: the Board voted the change in membership-composition Jan. 9, 1963.

6. Participation payments: in *all* cases of *over-income* subscribers, doctors will be paid by Blue Shield without need for assignments. When they give service benefits, all participating and non-participating doctors will be paid by Blue Shield. There will be no assignments. Under these procedures, doctors once again have flexibility in patient fees.

7. Rate increase approval: no more and no less than what Blue Shield has been doing for the past 23 years.

8. Participation signs: the Board will ask a participating doctor to display a sign, to be provided by Blue Shield.

9. Doctors submit reports within 180 days: the majority of doctors now submit their DSRs within 90 days.

"No Alternative"

Let me emphasize now that the Board of Directors of Blue Shield had little or no alternative but to accept the Consent Judgment. The sequence of events over the past several months had so set the stage that to turn the judgment down, finally, would have been suicide.

Blue Shield may have been able to emerge legally triumphant but financially busted, with no prepayment plan to reap the rewards of the victory.

Blue Shield was faced with a threat to the autonomy and life of the corporation. Management acted and the Board accepted.

Thousands of Children See Kent County Health Fair

Thousands of school children and adults from Western Michigan visited the Kent County Health Fair, held in Grand Rapids during Michigan Week.

Sponsored by the Kent Medical Foundation, the Health Fair sought to introduce to youngsters and their parents the many opportunities in medicine and health vocations.

(Editor's Note: A comprehensive summary of the Fair and photographs were not available for the July JOURNAL deadline and additional material and photos will appear in the August issue.)



Students at the right and two fathers at the left join Joseph R. Lentini, M.D., third from left, Health Fair general chairman, at the Michigan Health Council exhibit at the Kent County Health Fair in the Grand Rapids Civic Auditorium.

The Michigan Health Council held its annual meeting in Grand Rapids in conjunction with the Health Fair, and also developed a special careers exhibit. The Health Council exhibit featured closed circuit television camera with monitors so students could see themselves on television as "they would look as a medical doctor or nurse." Manikins dressed as a visiting nurse and a physical therapist completed the health-team exhibit, which proved to be among the popular Health Fair displays.

The Michigan State Medical Society exhibit sought to show the medical education facilities in Michigan. Small models showed the University of Michigan medical school complex, the proposed new Detroit Medical Center and Wayne State University College of Medicine, and the new pre-medical training facilities at Michigan State University.

The many other health organizations and commercial firms presented attractive exhibits.

Joseph R. Lentini, M.D., Grand Rapids, served as general chairman for the ambitious Health Fair, held at the Grand Rapids Civic Auditorium.

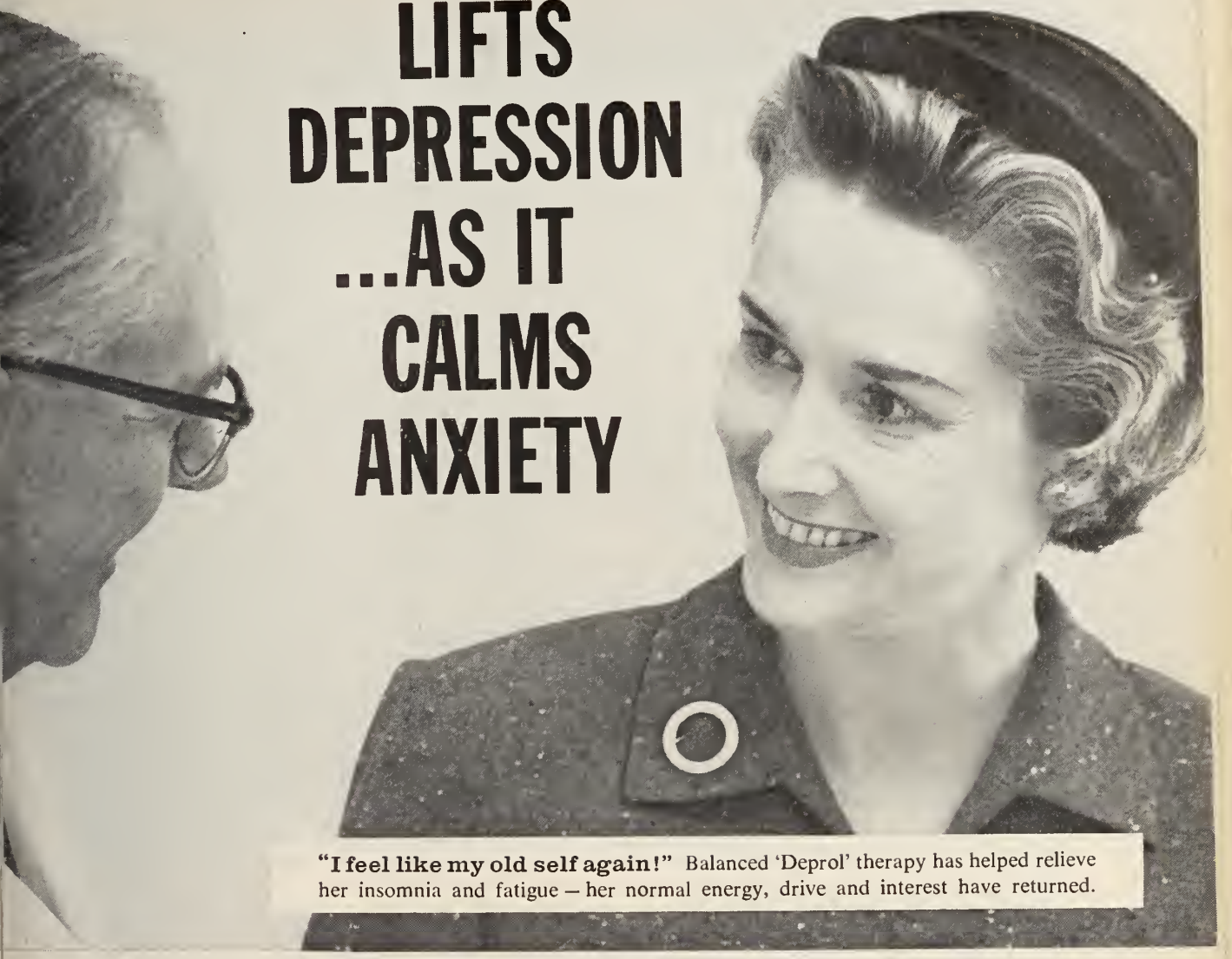
Dermatological Society Elects

Herschel S. Zackheim, M.D., Royal Oak, is the new president of the Detroit Dermatological Society for 1963-64.

The recent annual election saw the selection of David Kahn, M.D., Lansing, as the new president-elect. Serving this year as secretary-treasurer is Harold E. Usndek, M.D., Detroit, and as recorder, Harold Plotnik, M.D., Detroit.

(Continued on Page 692)

LIFTS DEPRESSION ...AS IT CALMS ANXIETY



"I feel like my old self again!" Balanced 'Deprol' therapy has helped relieve her insomnia and fatigue – her normal energy, drive and interest have returned.

Brightens mood...relaxes tension

Energizers may stimulate the depressed patient, but they often aggravate anxiety and insomnia. Tranquilizers may help the anxious patient, but they often deepen depression. 'Deprol' avoids these "seesaw" effects; it relieves both anxiety and depression. Moreover, it does not cause liver damage, psychotic reactions or changes in sexual function.

Slight drowsiness and, rarely, allergic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.

Usual Dosage: 1 tablet q.i.d. May be increased gradually, as needed, to 3 tablets q.i.d.; with establishment of relief, may be reduced gradually to maintenance levels.

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meprobamate 400 mg.
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reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem. KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.



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parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenol 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

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(Continued from Page 690)

"U-M Hospital-Internship Day" Scheduled for August 14

The annual "Hospital-Internship Day" at the University of Michigan will be held Wednesday, August 14. The meeting will be on the 7th floor of the Medical Science Building in Room 7330.

All Michigan hospitals approved for internship training are invited to participate. The event will begin at 11 a.m. and close at 4 p.m.

To Lead U-M Med Seniors

Richard W. Erbe of Ann Arbor has been elected president of The University of Michigan Medical School's 173-member senior class. Other officers elected are Hans O. Kaak of Vicksburg, Michigan, vice president; Pearl J. Campaan of Holland, Michigan, secretary and Richard Y. Mitsunaga of Honolulu, Hawaii, treasurer.

Booklet Offered for Cardiac Children

For parents of cardiac children, the Michigan Heart Association has available free copies of a revised booklet, "If Your Child Has a Congenital Heart Defect."

The booklet explains congenital heart defects in some detail, and stresses the need for planning by parents and defines problems that may arise at each step leading to surgery and beyond. Booklets are available from Michigan Heart Association, 13100 Puritan, Detroit 27.

State Provides APhA Leadership

Three Michigan men hold important positions in the American Pharmaceutical Association, following the recent convention in Miami Beach.

Robert J. Gillespie, St. Joseph pharmacist, is the new APhA president, with William B. Hennessy, Detroit, serving as a councilor, and Robert C. Johnson, Lansing, vice-chairman of the House of Delegates. Mrs. Reginald W. Lowe, Ann Arbor, is secretary of the APhA Women's Auxiliary.

Vanderbilt Alumni to Meet

The Vanderbilt Medical Alumni group will meet during the MSMS Annual Session on Thursday, September 26, 6:00 to 7:00 p.m. at the Pantlind Hotel in Grand Rapids. Members and their wives are invited for this hour of fellowship with adjournment in time to attend the Michigan State Medical Society Dinner Dance and to hear AMA President Edward R. Annis, M.D.



STARTING TOMORROW MORNING 

this capsule can help one of your overweight patients do without her favorite (fattening) foods at meals—and during all the hours in between.

Dexamyl® Spansule®

Trademark — brand of sustained release capsules

Each No. 2 capsule contains 15 mg. of Dexedrine® (brand of dextro amphetamine sulfate) and 1½ gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each No. 1 capsule contains 10 mg. of Dexedrine (brand of dextro amphetamine sulfate) and 1 gr. of amobarbital [Warning, may be habit forming].

The active ingredients of the 'Spansule' capsule are so prepared that a therapeutic dose is released promptly and the remaining medication, released gradually and without interruption, sustains the effect for 10 to 12 hours.

INDICATIONS: (1) For control of appetite in overweight; (2) for mood elevation in depressive states.

USUAL DOSAGE: One 'Dexamyl' *Spansule* capsule taken in the morning.

SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

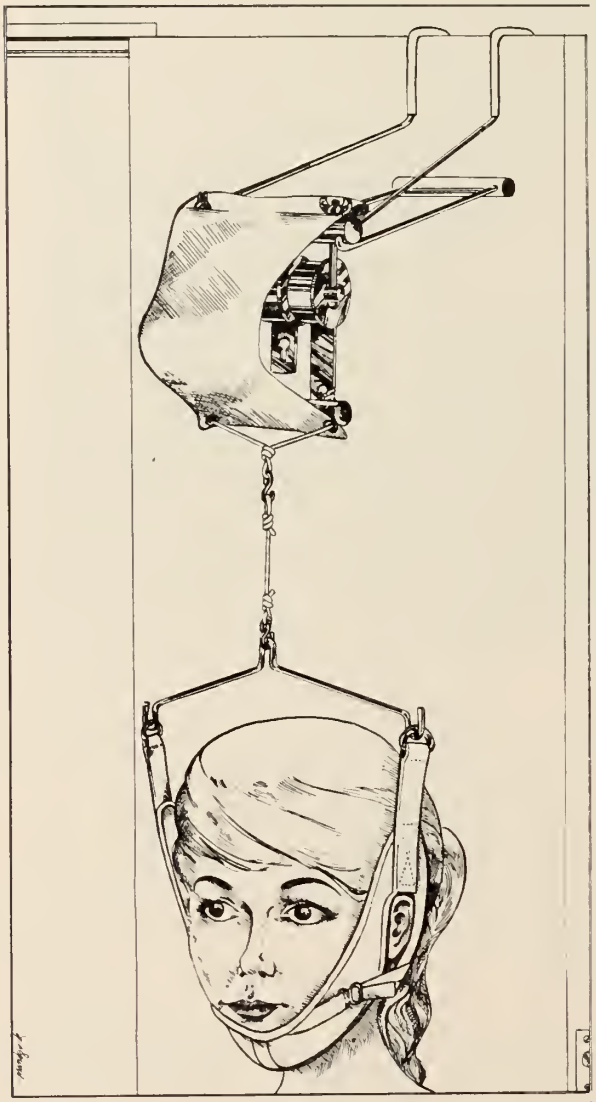
CAUTIONS: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these rare instances withdrawal of medication is recommended. It is generally recognized that in pregnant patients all medications should be used cautiously, especially in the first trimester.

SUPPLIED: Bottles of 50 capsules.

Smith Kline & French Laboratories SK&F *Prescribing information Jan. 1963*

New!

A cervical traction instrument in one small package. It folds away when not needed. Designed for doctor's offices, clinics, hospitals and home use. Model illustrated has calibrated 4 to 16 lbs. of traction. Lesser and greater capacities available.



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Hemoglobin—Grams Or Per Cent

Hemoglobin determination is one of the most useful procedures in medicine and yet it is one frequently subject to gross error of interpretation due to the custom of expressing hemoglobin values in "per cent."

At the turn of the century, Hayem proposed that hemoglobin be expressed in percentage figures and this has since become custom. Hayem's proposal has produced confusion because the normal hemoglobin value varies markedly in adult males and females and in children of various age groups, as is shown in the following table abbreviated and modified after Wintrobe and which is in essential agreement with our experience:

Age		*Sex*	*Hemoglobin in Grams/100 ML*		
1	Day	M & F	19.5	±	5.0
14-60	Days	M & F	14.0	±	3.3
3- 5	Months	M & F	12.2	±	2.3
1-15	Years	M & F	11.2	—	13.4
Adults		M.	16.0	±	2.0
Adults		F.	14.0	±	2.0

Further variations have been demonstrated to occur in other parts of the world. Therefore, one can readily see that selection of an arbitrary normal value (X Grams = 100%), applicable to all individuals is not possible.

A further complicating factor has been the practice of hemoglobinometer manufacturers to arbitrarily choose certain values to be the equivalent of 100%. These values have varied from 13.8 gm to 21 gm. This means that a hemoglobin of 100% as measured on one instrument would be determined as 66% on another.

The only way to make the percentage value meaningful would be to set up a gram-percentage normal for each age group, and for each sex after puberty but this would represent a needless complication of a relatively simple matter.

In summary, the practicing physician is urged to think of the patient's hemoglobin level in terms of Grams/100 ML of whole blood (a measured value) rather than in terms of percentage (someone's opinion as to that is normal).

"You cannot bring prosperity by discouraging thrift. You cannot strengthen the weak by weakening the strong. You cannot help the wage earner by pulling down the wage-payer. . . . You cannot further the brotherhood of man by encouraging class hatred. You cannot help the poor by destroying the rich. You cannot establish sound security on borrowed money. You cannot keep out of trouble by spending more than you earn. You cannot build character and courage by taking away man's initiative and independence. You cannot help man permanently by doing for men what they could and should do for themselves."—ABRAHAM LINCOLN.

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MICHIGAN DEPARTMENT OF HEALTH

ALBERT E. HEUSTIS M.D., State Health Commissioner

DIAGNOSIS OF RHEUMATIC FEVER
by Jones' criteria

MAJOR

1. CARDITIS

1 New significont murmur
2 E.C.G. changes
 a inverted T
 b prolonged P-R
3 Pericarditis
4 Heart foilure

2. POLYARTHRITIS

Chorocteristicolly
1 Red, hot ond swollen joints
2 Migrotes from one joint to onother
3 Involves middle-sized joints
4 Promptly relieved by Solicylates

3. CHOREA

1 Purposeless, uncontrolloble writhing, jerking movements of many ports of the body
2 Insidious onset
3 Associated with morked emotional instobility

4. SUBCUTANEOUS NODULES

over bony prominences especiolly over elbows, knees, scolp

5. ERYTHEMA MARGINATA

– Faint, flot, red norraw morgins
– Appear ond fode irregularly



MINOR

1. FEVER

May be a High and brief
 b Recurrent episades (cyclic)
 ar c Low grode persistent

2. ARTHRALGIA

if it skips from one joint to another & is relieved by Salicylates

3. PROLONGED P-R INTERVAL

– Normol vories for oge and heort rote

4. INCREASED SEDIMENTATION RATE OR LEUCOCYTOSIS

5. POSITIVE C REACTIVE PROTEIN

– Normolly not demonstroble
– Non-specific indicotar of inflammation

6. PRECEDING BETA. HEMOLYTIC STREPTOCOCCAL INFECTION

– Usuolly 8-28 doys

7. PREVIOUS RHEUMATIC FEVER

A DIAGNOSIS OF RHEUMATIC FEVER CAN BE ESTABLISHED BY FINDING:

A- **Two major criteria**
or
B- **One major PLUS two minor criteria**

As a part of its program of rheumatic fever control, the Michigan Department of Health provides to Michigan physicians, without charge, Benzathine Penicillin G for monthly injections to prevent recurrences of rheumatic fever in patients who have had one or more attacks of this disease.

The widespread use of anti-streptococcal prophylaxis makes the correct diagnosis of rheumatic fever increasingly important so that erroneously diagnosed cases are not subject to prophylactic treatment which may have some medical and psychological dangers. The strict

(Continued on Page 698)

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Diagnosis of Rheumatic Fever

(Continued from Page 696)

application of Jones' Criteria is considered necessary in the accurate diagnosis of rheumatic fever. Therefore, for the clinical diagnostic assistance it may give, the graphic illustration of Jones' Criteria is printed herewith, with the permission of Dr. O. E. Laxdal, Regina, and the Canadian Medical Association.

Further information regarding the distribution of Benzathine Penicillin G for the control of recurrences of rheumatic fever may be obtained by writing to the Division of Epidemiology, Michigan Department of Health, Lansing 4.

References: Jones, T. D., Diagnosis of Rheumatic Fever, JAMA 126:481, 1944; American Heart Association, Jones' Criteria (modified), Mod. Conc. Cardiov. Dis. 24:291, Sept. 1955; Grossman, Athreyn, Sources of Error in Diagnosis of Acute Rheumatic Fever in Children, JAMA 182:8, 1962.

The average prescription cost is $3.21 today compared with the average cost of 91 cents in 1939. But the average wage earner works 18 minutes less today to buy this drug that has remarkable curative and preventive powers and will return him to good health quicker and safer than ever before.

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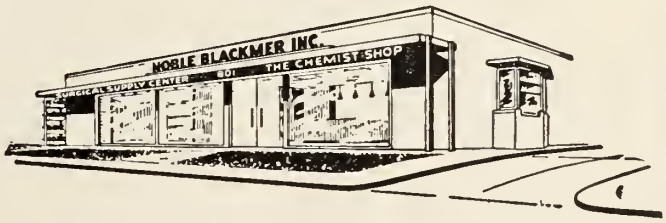
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Michigan Authors

C. Howard Ross, M.D., Ann Arbor, "Youth Penetrates the Later Years," *Journal of the American Geriatrics Society*, November, 1962.

Richard C. Schneider, M.D., and Carl A. Brinkman, M.D., Ann Arbor, "The Need for Urgent Therapy in Acute Contamination of the Closed Subarachnoid Space," *Surgery, Gynecology and Obstetrics*, April, 1963.

L. F. Bender, M.D., Ann Arbor, "Prevention of Deformities Through Orthotics," *Journal of the American Medical Association*, March 16, 1963.

Alexander Blain, III, M.D., Abas T. Zadeh, M.D., Manuel L. Teves, M.D., and Richard J. Bing, M.D., Detroit, "Lumbar Sympathectomy for Arteriosclerosis Obliterans," *Surgery*, February, 1963.

William J. Fry, M.D., Walter F. Keitzer, M.D., Richard O. Kraft, M.D., and M. S. DeWeese, M.D., Ann Arbor, "Prevention of Hypotension Due to Aortic Release," *Surgery, Gynecology and Obstetrics*, March, 1963.

J. W. Conn, M.D., Ann Arbor, "Aldosteronism in Man," *Journal of the American Medical Association*, March 2, 1963.

Gerald L. Brody, M.D. and Robert B. Sweet, M.D., Ann Arbor, "Halothane Anesthesia as a Possible Cause of Massive Hepatic Necrosis," *Anesthesiology*, January-February, 1963.

N. M. Bittrich, M.D., and A. V'r. Kane, M.D., and R. E. Mosher, M.D., Detroit, "Methonexital and Its Effect on Liver Function Tests," *Anesthesiology*, January-February, 1963.

Ryan Tolsma, M.D., Ann Arbor, "Externship in Nigeria," *The New Physician*, February, 1963.

Irwin J. Schatz, M.D., Detroit, "Occlusive Arterial Disease in the Hand Due to Occupational Trauma," *The New England Journal of Medicine*, February 7, 1963.

Mervin Boksenbaum, M.D., and C. G. Mendelson, M.D., Detroit, "Aseptic Necrosis of the Femoral Head and Steroid," *Journal, American Medical Association*, April 27, 1963.

Russell J. Vastine, M.D., Niles, "Civilian Aviation Medicine," *GP*, May 1963.

Milton W. White, M.D., Detroit, "The Etiology and Pathogenesis of Carcinoma, Leukemia, Possibly of Hodgkins, Determined By Results Found in Revised Culturing Procedures," published privately, 1963.

Samuel J. Nichamin, M.D., and Myron Kaufman, D.D.S., "Gingival Microcysts in Infancy," *Pediatrics*, March 1963.

Say you saw it in the Journal of the Michigan State Medical Society

Brief and to the Point...

HONORED—A certificate of recognition of 50 years in practice was given to Fred G. Swartz, M.D., Traverse City, at a recent meeting of the Tri-County Medical Society and Grand Traverse County Cancer Society. Doctor Swartz, who began practice in Traverse City 44 years ago, is medical director of the Grand Traverse Medical Care Facility, a past president of the local county medical society, and a past president of the Traverse City Chamber of Commerce.

* * *

CITED—The Japanese Minister of Health and Welfare recently awarded a "Third Class Order of the Rising Sun Medal of Japan" to Maurice H. Seevers, M.D., of Ann Arbor. Dr. Seevers recently returned from Japan after his fourth tour there to participate in medical meetings and to help officials there battle narcotics and other problems. On his last trip, he was the official AMA representative to the 16th All-Japan Medical Congress.

* * *

FETED BY COMMUNITY—Wilbur T. Claxton, M.D., who has practiced in the Britton area for 35 years, was honored recently at an event in the high school gymnasium. Village President Wayne Dunbar presented a bronze plaque from the community which honored Dr. Claxton "as a physician and friend to all in need." Archie O'Connor, M.D., chief of the staff at Herrick Hospital, Tecumseh, presented Dr. Claxton with a plaque to be placed on the door of a room at the hospital which will be used for family consultation and chapel services.

* * *

COLLEGE AWARDEE—Joseph C. Foust, a graduate of Aquinas College and a former Ionia physician, received the 5th Annual Aquinas College Award for his medical missionary work in Tanganyika. Doctor Foust will spend the summer in the States and then return to Tanganyika, where he moved with his family from Ionia in 1959.

* * *

WSU GRANTS—The Wayne State University College of Medicine recently received a grant from the National Institute of Health of $78,795 for myocardial metabolism research directed by Richard J. Bing, M.D., Birmingham; and an American Cancer Society grant of $75,000 for pulmonary cancer research directed by Arthur J. Vorwald, M.D., Detroit.

* * *

RE-APPOINTED—Governor George Romney recently re-appointed Winthrop Davey, M.D., Ann Arbor, and Paul T. Chapman, M.D., Detroit, to new terms on the Advisory Council on Tuberculosis Sanatoriums.

* * *

NATIONAL PRESIDENT—The new president of the American Pediatric Society is James Leroy Wilson, M.D., Ann Arbor. He was elected at the recent annual meeting in Atlantic City.



DIPLOMATE—One MSMS member recently reviewed certification as a Diplomate in pathology by the American Board of Pathology. He is Glenn W. Bylsma, M.D., Pontiac.

* * *

ELECTED SECRETARY—Dr. Russell T. Woodburne, Ann Arbor, has been named secretary-treasurer-elect of the American Association of Anatomists.

* * *

SPEAKER—Max Karl Newman, M.D., Detroit, was a participant in a recent program entitled "Cross Examination Strategy and Techniques" presented by the Institute of Continuing Legal Education in cooperation with the Indiana State Bar Association in Fort Wayne.

* * *

AHA RESEARCH—The American Heart Association has awarded Established Investigatoryships to F. James Conway, M.D., and John A. Penner, M.D., both of Ann Arbor. Dr. Conway will study aging of the arteries in relation to hypertension, and Dr. Penner will work on blood clotting problems.

* * *

ON PROGRAM—Several MSMS members were among the speakers at the annual clinical meeting of the American College of Obstetricians and Gynecologists in New York. They were C. Paul Hodgkinson, M.D., Detroit; Charles L. Schneider, M.D., Dearborn; Charles S. Stevenson, M.D., Grosse Ile; S. J. Behrman, M.D., Ann Arbor; Harold C. Mack, M.D., Detroit; Lee B. Stevenson, M.D., Detroit; George W. Morley, M.D., Ann Arbor; and Ralph V. August, M.D., Muskegon.

* * *

RE-ELECTED—Robin C. Buerski, M.D., Detroit, was recently re-elected a vice president of the Greater Detroit Area Hospital Council. The Council is considering a possible study of health care needs for long-term and rehabilitation institutions in southeastern Michigan.

* * *

CHOSEN—Marvin Sherman, M.D., Oak Park, was elected a vice president of the Multiple Sclerosis Society of Michigan at its recent annual meeting in Detroit.

* * *

AWARD WINNER—The University of Michigan Medical School recently bestowed the Henry Russel Award upon George D. Zuidema, M.D., an assistant professor of surgery. He is chairman of the junior medical staff of the University Hospital and a winner in 1960 of the Markle Scholarship award.

* * *

U. S. REPRESENTATIVE—Harold J. Magnuson, M.D., Ann Arbor, recently represented the United States at a conference on industrial health in Geneva, Switzerland. Held by the International Labor Office, the meeting sought to define the role of medicine in worker-health.

* * *

LIST COURSE—The annual course in postgraduate gastroenterology of the American College of Gastroenterology

Recent reports suggest...insulin and sulfonylureas may accelerate lipogenesis, fat accumulation, weight gain; thus appear to aggravate obesity in diabetics[1-5] *...serum "insulin" levels are often elevated in obese diabetics*[2,3,6]*...DBI (phenformin HCl) reduces high blood sugars, lowers elevated "insulin" levels, tends to reduce body weight toward normal.*[1,3,7-9]

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will be given at the Shoreham Hotel in Washington, D. C., October 24, 25, 26. The faculty will be drawn from the medical schools in and around Washington. For further information, write to the American College of Gastroenterology, 33 West 60th Street, New York 23.

* * *

ON PROGRAM—Four MSMS members participated on the program for the 12th annual conference of the Michigan Association for Retarded Children held at Alma College. They were Vernon A. Stehman, M.D., Lansing; Clarence Hoogerland, M.D., Alma; Anthony Abruzzo, M.D., Lapeer; and Robert I. Jaslow, M.D., Plymouth.

* * *

SPEAKER—Samuel J. Levin, M.D., Detroit, presented a paper entitled "Hyposensitization Therapy in Children" at the American College of Allergists in New York recently. He also read a paper at the 4th International Seminar on Repository Therapy which followed the College meeting.

* * *

OFFER AID—For practicing physicians, non-paying scholarships in clinical cardiology are being made available through the Michigan Heart Association at the University of Michigan Medical Center, Wayne State College of Medicine, and Henry Ford Hospital. Content and length of the scholarships, which will emphasize clinical practices in either adult or pediatric cardiology, will vary to suit the needs of individual physicians. For information write to the Medical Director, Michigan Heart Association, 13100 Puritan, Detroit 27.

BENTLEY NAMED—Alvin M. Bentley, industrialist and former Eighth District Congressman from Osseo, has been named chairman of the Michigan committee for Project HOPE. Mr. Bentley, with the assistance of Mrs. Gunnar Harlstrom of Birmingham, will head Michigan's activities in behalf of the hospital ship.

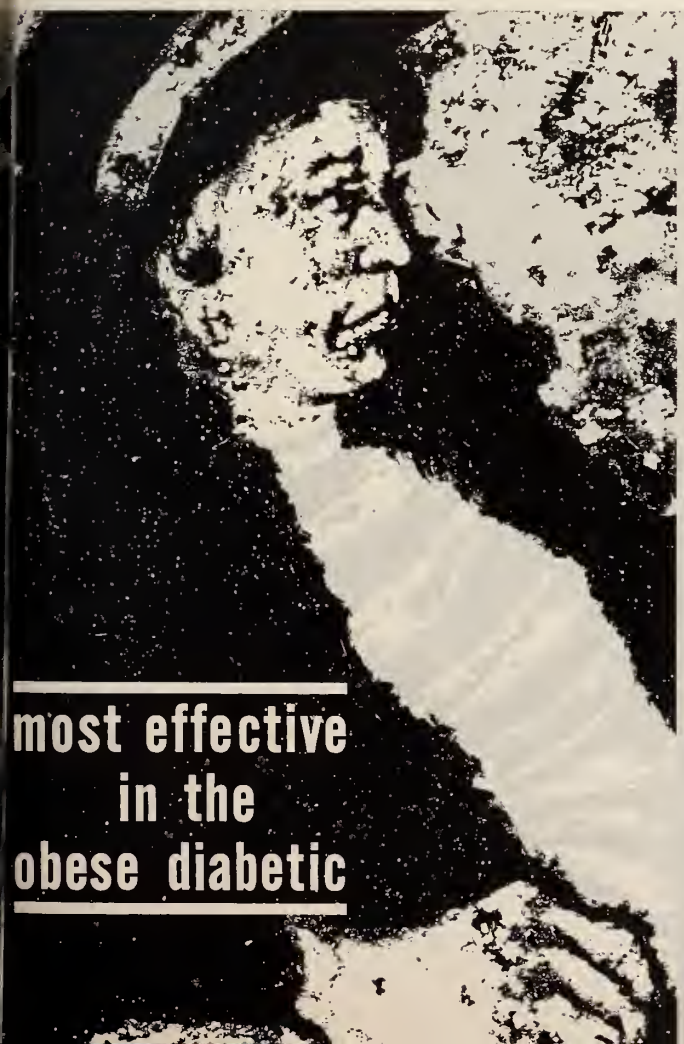
* * *

TWO MEMBERS HONORED—The Wayne County Medical Society has honored two of its members with a Distinguished Service Citation.

To Douglas Donald, M.D., for "contributing generously of his time and talent to the Wayne County Medical Society . . . worked on innumerable committees, served for many years as Delegate to the Michigan State Medical Society, as a member of The Council, as Trustee, and as President in 1948."

To Charles S. Kennedy, M.D., for spending "countless hours in founding and joining organizations—he has been President of every class he has attended . . . was founding member of The Academy of Surgery of Detroit, the Central Surgical Association, and the American Board of Surgery."

Good medical public relations depend upon the performance of the entire medical team, not just of a few "stars." Every doctor must practice individual public relations—but these PR efforts must be integrated and supplemented by more formalized campaigns by his medical societies.



DBI and DBI-TD (phenformin HCl),

administered to ketoacidosis-resistant diabetics requiring hypoglycemic therapy: **A.** act to reduce high blood sugar without increasing fat synthesis or weight gain as insulin and sulfonylureas tend to do. **B.** do not increase already elevated endogenous insulin levels; may, indeed, act to restore more normal insulin levels. **C.** favor reduction of weight towards normal.

Insulin is still the essential hypoglycemic agent for the ketoacidosis-prone diabetic. However, in the ketoacidosis-resistant obese diabetic phenformin appears to be the hypoglycemic of choice to help avoid weight gain or reduce adiposity, a factor tending to make control more difficult and to increase the likelihood of complications.

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Bibliography: 1. Williams, R. H.: Textbook of Endocrinology, Ed. 3, Saunders, Philadelphia, 1962, p. 610. 2. Gordon, E. S.: Metabolism 11:819, 1962. 3. Grodsky, G. M. et al.: Metabolism 12:278, 1963. 4. Sadow, H. S.: Metabolism 12:333, 1963. 5. West, K. M. and Tophoj, E.: Metabolism 10:689, 1961. 6. Yalow, R. S. and Berson, S. A.: Diabetes 9:254, 1960. 7. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. 8. Weller, C. et al.: Metabolism 11:1134, 1962. 9. Radding, R. S. et al.: Metabolism 11:404, 1962.

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IN MEMORIAM

FRANKLIN T. BOWER, M.D., 70, of Pleasant Ridge, died May 29, 1963.

A Detroit resident for 20 years, Doctor Bower retired in 1958 from the Ford Motor Company Medical Department. He was a graduate of the Jefferson Medical College, Philadelphia.

EDWARD K. CARMICHAEL, M.D., 73, Detroit physician since 1912, died April 26, 1963.

A graduate of the Detroit College of Medicine, Doctor Carmichael was one of the founders of the Jennings Memorial Hospital, served on its board of trustees from its beginning until 1954, and directed its diagnostic service since its inception in 1946.

He was a Life member of the Michigan State Medical Society.

WILLIAM G. ELLIOTT, M.D., 63, Detroit-area physician for 35 years, died May 5, 1963.

A 1925 graduate of the University of Illinois medical school, Doctor Elliott served his internship at University Hospital, Chicago, and his residency at Highland Park General Hospital.

He was a Past President of Highland Park General Hospital Medical staff and a member of the Emeritus staff after his retirement. He was a member of the American Academy of General Practice.

A. H. GOLDBERG, M.D., 61, Sault Ste. Marie physician, died April 28, 1963.

A native of Russia, Doctor Goldberg received his M.D. degree from the University of Illinois in 1927 and served his internship at Cook County Hospital, Chicago.

He practiced medicine in Sault Ste. Marie since his retirement from the Army in 1946. He was a former chief of staff at War Memorial Hospital.

EUGENE C. KEYES, M.D., 62, former Michigan lieutenant-governor, died May 2, 1963.

A native of Ontario, Doctor Keyes obtained a degree in dentistry from the University of Toronto in 1922. Later he came to Detroit and was graduated in 1931 from what is now the Wayne State University College of Medicine. In 1932 he opened Keyes Hospital in Dearborn, which he operated until his death.

He served as Michigan's lieutenant governor in 1943-44 and 1947-48, after starting in politics as a Dearborn city councilman.

WALTER I. LILLIE, M.D., 45, Grand Rapids surgeon, died May 24, 1963, of injuries suffered in an automobile accident.

Doctor Lillie was a 1941 graduate of the University of Michigan Medical School. After interning at Philadelphia General Hospital, he served in the U. S. Navy from 1942-46. In 1946 he was granted a fellowship to the Mayo Clinic at Rochester, Minnesota, where he was a resident surgeon until

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coming to Grand Rapids in 1950. He also obtained a graduate degree in surgery from the University of Minnesota at that time.

Doctor Lillie was on the general surgery staffs of St. Mary's, Butterworth, Blodgett Memorial and Ferguson-Droste-Ferguson Hospitals. He was a fellow of the American College of Surgeons.

RUDOLPH L. PFEIFFER, M.D., 84, Detroit practitioner for 60 years, died early in May.

A 1903 graduate of the Detroit College of Medicine and Surgery, Doctor Pfeiffer had been a staff member at Evangelical Deaconess Hospital since 1917 and chief of staff in 1940 and 1941.

DONALD W. THORUP, M.D., 60, Benton Harbor obstetrician and gynecologist since 1934, died April 25, 1963.

A native of Iowa, Doctor Thorup was a graduate of the University of Chicago Medical School in 1929. He was chief of obstetrics at Mercy and Memorial Hospitals and a former chief of staff at Mercy Hospital.

He was a Past President of the Berrien County Medical Society and a Berrien County Medical Society Delegate to the MSMS House of Delegates from 1942 to 1959. For a number of years he served on the MSMS Maternal Health Committee. He was a fellow of the American College of Surgeons, and the American College of Obstetricians and Gynecologists.

PAUL J. WALTZ, M.D., 55, former West Branch and Highland Park physician, died April 29, 1963, in Arizona.

A 1942 graduate of the Wayne State University College of Medicine, Doctor Waltz practiced for 14 years in Highland Park before beginning practice in West Branch in 1957. He was a Past President of the North Detroit Medical Society and a former Delegate from Wayne County Medical Society to the MSMS House of Delegates.

Letters to the Editor

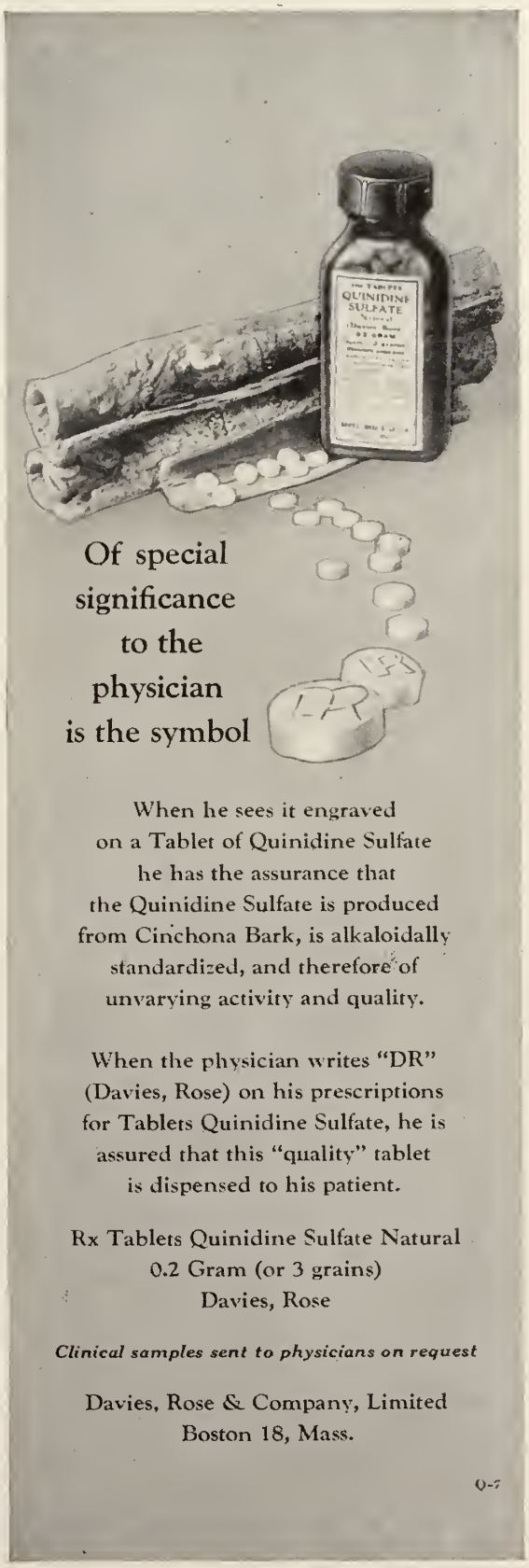
Dear Doctor Haughey:

I want to express my grateful thanks to the Michigan State Medical Society for having your President, Dr. Clarence I. Owen, attend the Annual Congress in Medical Education and Licensure when I was elected President of the Medical Board of Examiners of the United States.

The Michigan State Board of Registration in Medicine will look for cooperation and active support from the Michigan State Medical Society so that we may steer with safety, the programs of Medicine, in which we are all interested, amidst the conflicting elements of a troubled world.

Sincerely yours,
E. C. Swanson, M.D.
Executive Secretary
Michigan State Board of Registration in Medicine

Lansing, Michigan
March 15, 1963



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The Doctor's Library

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

BOOKS RECEIVED

SPECIFIC AND NON-SPECIFIC FACTORS IN PSYCHOPHARMACOLOGY. Proceedings of a Symposium Held at the Third World Congress of Psychiatry, in Montreal, Canada, June 4-10, 1961. Edited by Max Rinkel, M.D. New York: Philosophical Library, 1962. Price, $3.75.

YOUR WEIGHT AND HOW TO CONTROL IT. Revised Edition. Edited by Morris Fishbein, M.D., Editor, Modern Home Medical Adviser and Popular Medical Encyclopedia. Garden City, New York: Doubleday & Company, Inc., 1963. Price, $3.95.

THE EXOCRINE PANCREAS. Normal and Abnormal Functions. Ciba Foundation Symposium. Editors for the Ciba Foundation: A. V. S. De Reuck, M.Sc., D.I.C., A.R.C.S., and Margaret P. Cameron, M.A. 91 illustrations. Boston: Little, Brown and Company, 1962. Price, $11.50.

MEDICAL RESIDENT'S MANUAL. By Frank B. Flood, Resident in Medicine and Research Fellow of the New York Heart Association at St. Vincent's Hospital of the City of New York; Richard J. Kennedy, Associate Director of Medicine, St. Vincent's Hospital of the City of New York; William J. Grace, Director of Medicine, St. Vincent's Hospital of the City of New York and Professor of Clinical Medicine, New York University School of Medicine. New York: Appleton-Century-Crofts Division of Meredith Publishing Company, 1962. Price, $4.95.

SYNOPSIS OF OBSTETRICS. By Charles E. McLennan, M.D., Professor of Obstetrics and Gynecology, Stanford University School of Medicine, Palo Alto, California. Sixth edition with 157 illustrations, including 4 in color. St. Louis: C. V. Mosby Company, 1962. Price, $6.75.

ADVANCES IN RHEUMATIC FEVER 1940-1961. By May G. Wilson, M.D., Professor of Clinical Pediatrics, Emeritus, Cornell University Medical College; Consulting Pediatrician and Director, Rheumatic Fever Research, The New York Hospital, New York City. A Commonwealth Fund Book published by Hoeber Medical Division. New York: Harper & Row, 1962. Price, $10.00.

ESSENTIALS OF PEDIATRIC PSYCHIATRY. By Reuben Meyer, M.D., Associate Professor of Pediatrics, Wayne State University College of Medicine; Attending Pediatrician, Children's Hospital of Michigan. Morton Levitt, Ph.D., Professor of Psychology in Psychiatry and Assistant Dean, Wayne State University College of Medicine. Mordecai L. Falick, M.D., Associate Professor of Psychiatry, Wayne State University College of Medicine; Training Analyst, Psychoanalytic Training Center of Detroit. Ben O. Rubenstein, Ph.D., Associate Professor of Psychiatry, Wayne State University College of Medicine. New York: Appleton-Century-Crofts (Division of Meredith Publishing Company). (no price given)

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PLAN FOR PSYCHIATRIC RESIDENCY for July, 1964? NIMH General Practitioner Program: $12,000 yearly, partially tax free. Michigan vacationland. Three-year approved. Balanced didactic and clinical training. Dr. Curtis W. Page, Training Director, Traverse City State Hospital, Traverse City, Michigan.

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SURGEON: Experienced in trauma to join five-man group doing general surgery, industrial and limited orthopedic work. Young man to start on salary and full expenses; partnership in group for right man. Must be capable and experienced, no new residency graduates. Boards not required if background sufficient. Résumé to Wm. C. VanGelder, M.D., 205 Medical Arts Bldg., Muskegon, Michigan.

FOR LEASE: Medical Suite near Southgate shopping center. Air conditioned. Private parking lot. Very desirable area. Contact E. F. Hall, D.D.S., 13046 Eureka, Southgate, Michigan. Phone AV 2-4838.

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WANTED: Additional Obstetrician-Gynecologist for Northern Minnesota General Practice and Specialty Group. Early Partnership. Contact A. M. Antonow, M.D., East Range Clinic, Virginia, Minnesota.

SENIOR STAFF PHYSICIAN wanted to fill vacanacy in Oakland County Tuberculosis Sanatorium as soon as possible. Applicant should be a graduate of an American Medical School and possess a State Board license to practice medicine in the State of Michigan. Applicant should be interested in internal medicine, particularly in tuberculosis. The scale of salary is to be determined according to qualifications and experience of the individual. We have Social Security, generous vacation, sick leave, retirement plans and group life insurance. Direct application to Dr. John D. Monroe, Superintendent, Oakland County Tuberculosis Sanatorium, Union Lake, Michigan.

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FOR SALE: Detroit. Golden opportunity for young physician to buy long-established general practice with completely furnished office. Easy terms, will introduce and assist in every way possible. Contact: C. M. Clark, M.D., 2605 Holbrook Ave., Detroit 12, Michigan.

PHYSICIANS WANTED: Locum Tenens, August 5-18 and August 26-September 7. Diagnostic Radiology—Two small hospitals in Detroit. Will accept residents who have completed two years of Diagnostic Radiology. Michigan license required. Reply: Box 16, 120 West Saginaw Street, East Lansing, Michigan.

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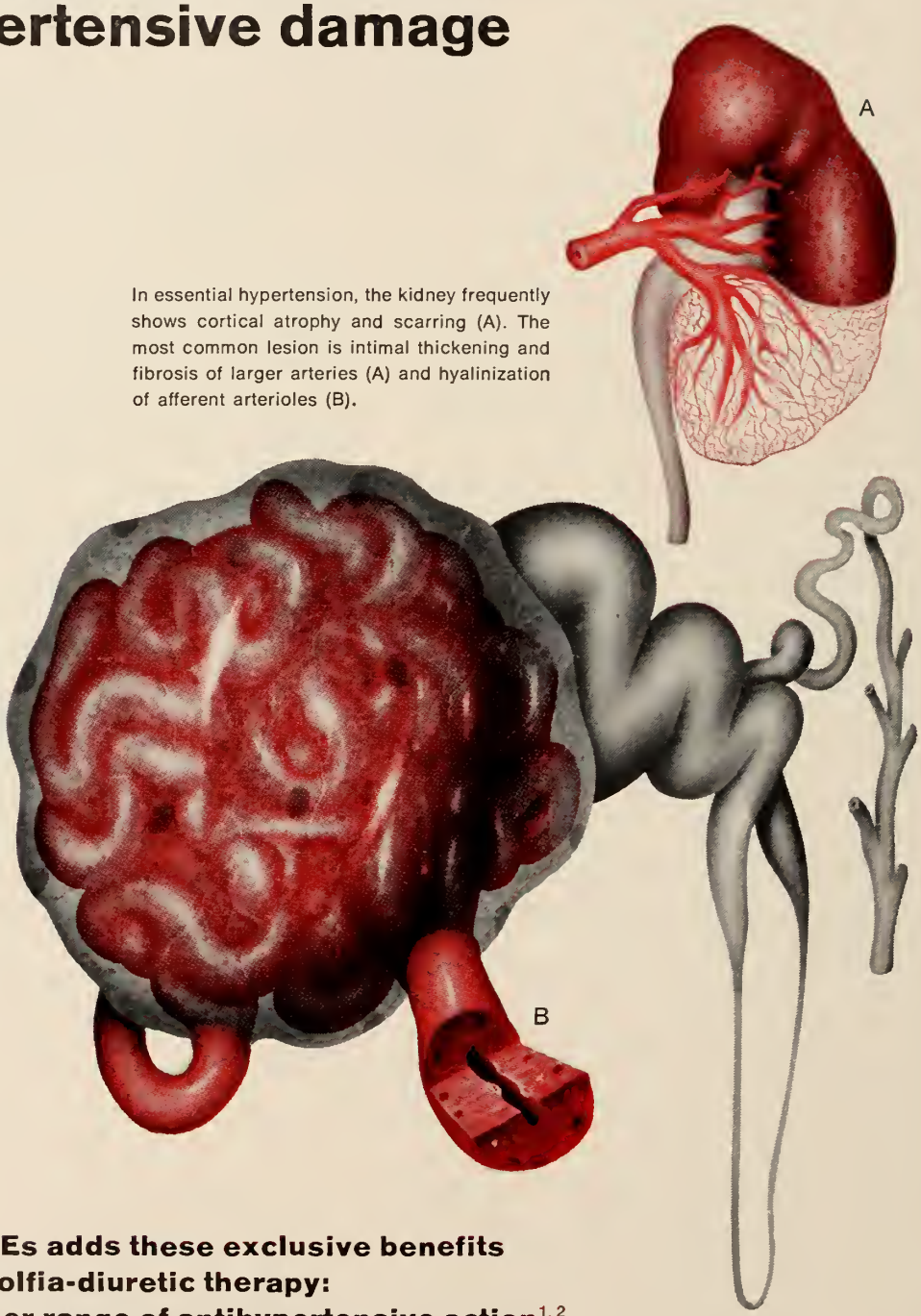
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President's Page

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Clarence D. Owen

President

Michigan State Medical Society

For medicine, we can say that these are the best of times, and the worst of times for medicine.

Does that sound contradictory?

Let me explain myself . . .

During the past year as your president, I have talked to many medical statesmen in our own component societies and in the other states that I have visited; and I have discussed health matters with many non-medical leaders, such as legislators, editors, school officials, and leaders in other professional groups.

These people, in our conferences, often have led to this complex dual conclusion that these are both the best of times and the worst of times for medicine.

These are the best of times for medicine—because never before have members of the medical profession been able to help their fellow man live such long, useful lives.

And these are the worst of times for medicine—because never have we been under such critical attacks.

Edward R. Annis, M.D., President of the AMA, in his speeches often views this serious condition by saying, "As physicians and surgeons, we have been so preoccupied with bringing the best of medical care to the American people that we have neglected our role as citizens. As a result, others have created our image and it is a false image."

As your president, may I urge you to participate in the 1963 Annual Session of the Michigan State Medical Society to increase your medical knowledge and to deepen your insights into the non-medical battles we must win. Send your reservations in today to hear Doctor Annis speak at our Annual Session State Society Night Dinner Dance September 26 at the Grand Rapids Civic Auditorium.

AMA President Annis and our own Incoming MSMS President O. J. Johnson need the active participation of each of you as we provide quality medical care for all and as we increase our socio-economic knowledge and our political action.

We must engage even more effectively in the traditional offense against disease and death. And all of this may be for naught if we do not decisively turn back the bitter efforts of some segments of today's society against medicine. These misguided people must not be permitted to take from the individual physician his privilege to make decisions in the client's best interest based upon knowledge, skill and dedication to professional principles and standards.

Annis, Romney Top Annual Session Names

Two of the nation's most-sought-after speakers will address Michigan physicians during the week-long MSMS Annual Session in Grand Rapids September 22-27. They are

. . . Edward R. Annis, M.D.

. . . George Romney

Doctor Annis, a native of Michigan, will address the 1963 MSMS Annual State Society Night, Thursday, September 26 in the Civic Auditorium.

Governor Romney will make his appearance before the Michigan State Medical Society House of Delegates on Monday, September 23, at 11:00 A.M.

* * *

IT WILL BE "OLD HOME WEEK" for Doctor Annis, who was born in Detroit, March 27, 1913 and was graduated with a BS degree in 1933 from the University of Detroit. He went to medical school at Marquette University and has practiced in Florida since 1938. In 1948, he moved to Miami where he practices surgery. It was while serving as chairman of the AMA's Speakers Bureau that he won prominence as a speaker and debater, appearing on several nationally televised programs. In June, 1962, he was chosen as President-Elect; this past June in Atlantic City, he was installed as president.

Doctor Annis made several major addresses in Michigan while serving as President-Elect of the AMA. He spoke to the Detroit Economic Club and the 1963 Congress of the Professions in Lansing. Prior to that he was the featured speaker of the 1962 Lansing Convention of the Michigan State Chamber of Commerce.

* * *

MICHIGAN PHYSICIANS ARE urged to plan now to attend the 1963 MSMS Annual State Society Dinner Dance program in Grand Rapids. The evening will feature not only the address by Doctor Annis but also cocktails, an excellent dinner, a fast floor show, and dancing. An order blank for tickets ($7.00 per person) was recently mailed to every MSMS member as part of the July MSMS President's Letter.

The program for the 1963 Annual Scientific Session, September 25-27, appeared in the July JOURNAL and was also a part of the July MSMS President's Letter sent to every MSMS member.



James J. Lightbody, M.D.
Speaker, House of Delegates
Michigan State Medical Society

Dear Dr. Lightbody:

Thank you very much for your letter of July 1, 1963, inviting me to address the House of Delegates of the Michigan State Medical Society on Monday, September 23 at 11:00 A.M. in the Ballroom of the Pantlind Hotel at Grand Rapids.

I would be most pleased to extend a few words at the Michigan State Medical Society meeting, and will look forward to being with you on September 23 at 11:00 A.M.

Sincerely,
GEORGE ROMNEY

1963 MSMS Annual Session

Wednesday-Thursday-Friday, September 25-26-27
Pantlind Hotel-Civic Auditorium, Grand Rapids

Meetings of MSMS Sections and Ancillary Groups

Wednesday, September 25

The MSMS SECTION ON DERMATOLOGY will sponsor a luncheon-meeting beginning at 12:30 p.m. in Room 222 of the Pantlind Hotel. Allan L. Lorincz, M.D., of Chicago will speak on "Allergic Reactions of the Skin." For details, please contact F. V. Hauser, M.D., Chairman, 1015 Mott Foundation Bldg., Flint 2.

The MSMS SECTION ON OBSTETRICS AND GYNECOLOGY and the MICHIGAN SOCIETY OF OBSTETRICS AND GYNECOLOGY will meet jointly at 12:30 p.m. for reception luncheon, and meeting in the Continental Room of the Pantlind Hotel. The program will be a discussion of "Control of Ovulation" by Allan C. Barnes, M.D., Baltimore; Samuel J. Behrman, M.D., Ann Arbor, Moderator; Robert W. Kistner, M.D., Brookline, Mass., and Robert W. Noyes, M.D., of Nashville, Tennessee. For details, please write Section Chairman R. P. Nanzig, M.D., 153 Lafayette S.E., Grand Rapids, or MSOG Secretary Robert G. Swanson, M.D., Professional Bldg., Detroit 36.

The MSMS SECTION ON UROLOGY AND the DETROIT BRANCH OF THE AMERICAN UROLOGICAL ASSOCIATION, INC., will meet jointly beginning at 5:30 p.m. The speaker is Wm. L. Parry, M.D., Oklahoma City, Oklahoma, who will speak on "Interesting Aspects in Urology." A reception is scheduled for 6:30 p.m. followed by dinner at 7:00 p.m. The meeting and dinner will be in Room 323 of the Pantlind Hotel. For details, contact Section Secretary Murray S. Mahlin, M.D., 16820 Greenfield Ave., Detroit 35.

The MSMS SECTION ON INTERNAL MEDICINE will meet at 5:30 p.m. in the Grand Rapids Room of the Pantlind Hotel. George E. Schreiner, M.D., Washington, D.C., will speak on "Toxic Nephropathy, Including the Nephritis of Analgesic Abuse." Following Doctor Schreiner's talk and a brief business session, there will be a reception honoring Doctor Schreiner. For details, contact Section Chairman John D. Littig, M.D., 1324 S. Park, Kalamazoo.

The MICHIGAN CLINICAL SOCIETY OF DIABETES will meet at 2:00 p.m., followed by reception, dinner, and an evening meeting, in the Ballroom of the Pantlind Hotel. All members of the State Society are cordially invited.

Chairman: Keats K. Vining, Jr., M.D.
Chairman Clinical Division Michigan Diabetes Association
Grand Rapids, Michigan

2:00 P.M. "Management of the Difficult or Brittle Diabetic"
Priscilla White, M.D., Joslin Clinic, Boston, Massachusetts

2:40 P.M. "Treatment of Obesity in the Diabetic"
Fred W. Whitehouse, M.D., Henry Ford Hospital, Detroit, Michigan

3:10 P.M. "Diabetes Detection, Where Are We Going With It?"
Frank S. Perkin, M.D., Chairman Michigan Diabetes Detection Program, Detroit, Michigan

3:40 P.M. "Management of the Asymptomatic New Diabetic"
John C. Floyd, Jr., M.D., University Medical Center, Ann Arbor, Michigan

4:15 P.M. Panel: "Is Early Detection and Treatment Going To Effect Complications?"
Drs. White, Whitehouse, Perkin, Floyd and Goetz
Moderator—Dr. Whitehouse

6:30 P.M. Banquet—Walter Anderson, M.D., President Michigan Diabetes Association, Detroit, Michigan, Presiding
Speaker—Current Concepts of Insulin Action, Fred C. Goetz, M.D., Department of Medicine, University of Minnesota, Minneapolis, Minnesota
Reservations for dinner can be made in advance.
For details, contact Keats K. Vining, Jr., M.D., 515 Lakeside Dr. S., Grand Rapids.

The MSMS SECTION ON NERVOUS AND MENTAL DISEASES and the MICHIGAN SOCIETY OF PNEUROLOGY AND PSYCHIATRY and MICHIGAN DISTRICT BRANCH, AMERICAN PSYCHIATRIC ASSOCIATION will meet at 6:00 p.m. for a reception followed by dinner at 8:00 p.m. and an evening meeting at 9:00 p.m. in the Sadler Lounge of the Pantlind Hotel. Marc H. Hollender, M.D., of Syracuse, New York, will speak on "Selection of Patients for Definitive Types of Psychotherapy." For details, write Section Chairman George H. Reye, M.D., 2765 Flushing Road, Flint 4.

The MSMS SECTION ON RADIOLOGY will meet jointly with the WEST MICHIGAN SECTION OF THE DETROIT ROENTGEN AND RADIUM SOCIETY at 6:15 p.m. for reception, 7:15 p.m. for dinner followed by an evening meeting beginning at 8:00 p.m. in Rooms 322 and 324, Pantlind Hotel. The Speaker is Juan M. Taveras, M.D., of New York City who will discuss "Radiologic Diagnosis of Carotid Insufficiency." For details, contact Section Chairman B. R. VanZwalenburg, M.D., 2054 Anderson Dr. S.E., Grand Rapids.

Wednesday, September 25 (Continued)

The MICHIGAN COMMITTEE ON TRAUMA, AMERICAN COLLEGE OF SURGEONS, will meet for cocktails and luncheon at 12:00 noon followed by an afternoon meeting in the Aloha Room of the Pantlind Hotel. For details, write Harvey Andre, M.D., Program Chairman, 500 Cherry, Grand Rapids.

Thursday, September 26

The MICHIGAN ACADEMY OF PLASTIC SURGERY will hold a scientific session beginning at 10:30 a.m. in Room 328 of the Pantlind Hotel, with luncheon at 12:30 p.m. in Room 327. A business meeting will be held after the luncheon in Room 328. For details, please contact Ralph Blocksma, M.D., President, 245 Professional Bldg., Grand Rapids 2.

The MSMS SECTION ON OPHTHALMOLOGY will meet at 5:00 p.m. in Room 323 of the Pantlind Hotel. Speaker and subject to be announced. For details, write Wm. Arendshorst, M.D., Section Chairman, 144 West 26th St., Holland.

The MSMS SECTION ON OTOLARYNGOLOGY will meet at 4:00 p.m. in Room 327 of the Pantlind Hotel. The speaker is Wm. H. Wilson, M.D., Denver, Colorado, who will talk on "Management of Otogenic Vertigo." For details, contact Section Chairman G. Donald Albers, M.D., 203 Paris, Grand Rapids 3.

The MSMS SECTION ON OCCUPATIONAL MEDICINE will meet at 5:00 p.m. in Room 222, Pantlind Hotel. Joseph N. Schaeffer, M.D., of Detroit will speak on "Physical Medicine and Rehabilitation as Related to Occupational Medicine." Following Doctor Schaeffer's talk and a brief business session, there will be a reception honoring Doctor Schaeffer. For details, contact Section Chairman Martin F. Bruton, M.D., 341 Massachusetts, Detroit 31.

The MSMS SECTION ON GASTROENTEROLOGY AND PROCTOLOGY will meet for luncheon at 12:30 p.m. in Rooms 322 and 324 of the Pantlind Hotel. The speaker at this Section meeting is H. Marvin Pollard, M.D., Ann Arbor, who will discuss "Genetic Aspects of Intestinal Disease." For details, please write Section Chairman Howard G. Benjamin, M.D., 72 Sheldon Ave. S.E., Grand Rapids.

The MSMS SECTION ON SURGERY will meet at 5:00 p.m. in the Continental Room of the Pantlind Hotel. Isidore Cohn, Jr., M.D., New Orleans, Louisiana, will talk on "Intestinal Obstruction," and Chester B. McVay, M.D., Yankton, South Dakota, will present "Inguinal Herniоplasty." For details, contact Section Chairman Alexander Blain, III, M.D., 2201 E. Jefferson, Detroit 7.

The MSMS SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE will meet at 5:00 p.m. in Room B of the Civic Auditorium. The speaker is Saul Krugman, M.D., of New York City, who will talk on "Gamma Globulin Prophylaxis." For details, contact Section Chairman A. E. Heustis, M.D., Michigan Department of Health, Lansing, Michigan.

The VANDERBILT MEDICAL ALUMNI ASSOCIATION will sponsor a "get-together" reception between the hours of 6:00 and 7:00 p.m. in Rooms 322-324 of the Pantlind Hotel. Adjournment will be in time for members to attend the MSMS State Society Dinner Dance. For details, contact J. C. Foshee, M.D., President, 124 Fulton St. S.E., Grand Rapids.

Friday, September 27

The KENT COUNTY CHAPTER, MICHIGAN EPILEPSY ASSOCIATION will meet for luncheon at 11:45 a.m. in Room 222 of the Pantlind Hotel. The speaker is James G. Hughes, M.D., of Memphis, Tennessee. For details, contact Mrs. Roland R. Benson, Chairman, 1578 Pontiac Rd. S.E., Grand Rapids 6.

The MSMS SECTION ON PATHOLOGY and the MICHIGAN PATHOLOGICAL SOCIETY will meet jointly for luncheon at 12:00 noon in the Kent State Room, Pantlind Hotel. A scientific session will follow from 2:00 to 5:00 p.m. A panel presentation will be presented on the subject "Use of Radioisotopes for Diagnostic Purposes." The participants of the discussion group are: Wm. G. Battaile, M.D., Washington, D. C.; Oscar B. Hunter, M.D., Washington, D. C.; and Robert E. Mack, M.D., Detroit. For details and luncheon ticket, write: Harold E. Bowman, M.D., Secretary, Michigan Pathological Society, 201 Lafayette Avenue S.E., Grand Rapids.

The MSMS SECTION ON PEDIATRICS and the MICHIGAN BRANCH, AMERICAN ACADEMY OF PEDIATRICS will meet at 1:00 p.m. for luncheon at St. Mary's Hospital in Grand Rapids; followed by case presentations, from 2:30 to 4:00 p.m., on "Clinical Virology" with Saul Krugman, M.D., of New York City and James G. Hughes, M.D., of Memphis, Tennessee, present to answer questions. Reception and dinner are scheduled for 6:00 p.m. in the Continental Room of the Pantlind Hotel followed by a talk by G. Don Cummings, M.D., of Lansing on "The Michigan Department of Health Laboratories." For details, please contact Section Chairman Bernard H. Siebers, M.D., 1085 Leonard St. N.E., Grand Rapids.

THE WOMAN'S AUXILIARY TO THE MICHIGAN STATE MEDICAL SOCIETY will hold its Annual Session at the Pantlind Hotel in Grand Rapids, September 24 to 26. A most cordial invitation is extended to all doctors' wives and their guests. Read over the following convention program and plan to attend the meetings to learn about Auxiliary activities and projects.

A special feature of the convention will be the Art Exhibit sponsored by the Auxiliary in the Civic Auditorium near the Scientific Exhibits. All doctors, as well as doctors' wives, who would like to exhibit their works of art should contact Mrs. R. A. Rasmussen, 2630 Middleboro Lane N.E., Grand Rapids; or Mrs. Leonard Rozenzweig, 2638 Reed Lake Blvd. S.E., Grand Rapids. The judge of the Art Exhibit will be Mr. Gerald Mast, Extension Instructor in Art of the University of Michigan.

There will be time to shop, to visit the Decorative Arts Center and Furniture Displays in the Waters Building, and to view the Art Exhibit.

Urge your husbands to take you to the "State Society Night" on September 26 to hear Edward R. Annis, M.D., President of the AMA.

WOMAN'S AUXILIARY, MICHIGAN STATE MEDICAL SOCIETY

Thirty-seventh Annual Meeting

Pantlind Hotel—Grand Rapids

September 24-26, 1963

PROGRAM

Tuesday, September 24

P.M.

12:00 Registration on Mezzanine, Pantlind Hotel
Hospitality Room Opens—Parlor A

1:30 Planning Conference and Executive Committee Meeting—Sadler Lounge
Those who attend:
1962-63 and 1963-64 State Officers, Directors, Chairmen, National Representative, and Honored Guests

3:00 Art Exhibit Opens—Civic Auditorium

Wednesday, September 25

A.M.

9:00 Continental Breakfast—Red Room, Civic Auditorium

9:30 Pre-Convention Board Meeting—Red Room, Civic Auditorium (for State Officers, Directors, Chairmen, County Presidents, Presidents-Elect, National Representative, and Guests)

9:45 Formal Opening of the 37th Annual Meeting of the Woman's Auxiliary to the Michigan State Medical Society—Red Room, Civic Auditorium—Mrs. Ross V. Taylor, Presiding
(Delegates and Board Members will please register with the Roll Call Chairman at the door before the opening of each session, thus eliminating the need of an oral roll call.)
Invocation: Rev. Hugh Michael Beahan, Chaplain, Mount Mercy Academy
Pledge of Allegiance to the Flag and Woman's Auxiliary Pledge
Address of Welcome: Mrs. J. D. Plekker, President, Kent County Auxiliary
Introduction of Guests
Introduction of Convention Chairmen: Mrs. Roland R. Benson and Mrs. Robert J. Westerhoff
Report of Roll Call Chairman, Mrs. James A. Ferguson
Convention Rules of Order: Mrs. John Ganschow, Parliamentarian
Adoption of Convention Program
Announcements
Minutes of the 36th Annual Convention
Report of the President: Mrs. Ross V. Taylor
Reports of Officers:
President-Elect—Mrs. R. J. Himmelberger
First Vice President—Mrs. Milton Weed
Second Vice President—Mrs. R. H. Reitzel
Recording Secretary—Mrs. E. P. Griffin
Corresponding Secretary—Mrs. W. A. Joerin
Financial Secretary—Mrs. K. E. Fellows (Including Auditor's Report)
Treasurer—Mrs. Jack Hoogerhyde
Members-at-Large Coordinator—Mrs. Albert Myer
Parliamentarian—Mrs. John Ganschow
Report of Finance Committee and Presentation of the 1963-64 Budget: Mrs. F. P. Rhodes, Chairman
Report of the Committee on Revisions: Mrs. Clarence Crook, Chairman
AMA-ERF Awards: Mrs. W. G. Gamble, Jr., Chairman
Report of the Registration and Credential Committee: Mrs. John Tenhave
Program Session: "S.A.C." "Serve and Communicate" by State Committee Chairmen:
AMA-E.R.F.—Mrs. W. G. Gamble, Jr.
Auxilium Editor—Mrs. F. Mansel Dunn
Bulletin—Mrs. Robert W. Brown
Civil Defense, Safety, and Program—Mrs. R. H. Reitzel
Community Service—Mrs. Milton Weed
Health Careers—Mrs. Donald Bolstad
International Health Activities—Mrs. R. Fred Hauer
Legislation—Mrs. Norbert T. Pasternacki
Mental Health—Mrs. Warren S. Wille
Membership—Mrs. R. J. Himmelberger
Press—Mrs. H. P. Koistra
Rural Health—Mrs. William C. Heitsch
TB and Respiratory Disease Speaking Project—Mrs. Edwin C. Galsterer

P.M.

12:30 Past President's Luncheon—Kent State Room—Pantlind Hotel
Honoring Mrs. William Mackersie, Past President of the Woman's Auxiliary to the AMA; Past Presidents of the Woman's Auxiliary to the MSMS; Mrs. Leo Parnagian, President of the Woman's Auxiliary to the Student AMA; Representatives of the Michigan State Medical Society; and Honored Guests
Introduction of Guests
Greetings: O. J. Johnson, M.D., President MSMS
Carl B. Beeman, M.D., President, Kent County Medical Society
Guest Speaker: Representative of the Woman's Auxiliary to the American Medical Association

2:30 Résumé of General Session—Red Room—Civic Auditorium
Continuation of Program Session by State Chairmen
District Directors' and County Presidents' Reports
"This Is Our Best"—Exchange of Ideas for Programs and Projects
Recess—(County Reports to be continued Thursday Morning)

Thursday, September 26

A.M.

9:00 Continental Breakfast—Red Room—Civic Auditorium

9:30 General Meeting of the Woman's Auxiliary to the MSMS—Mrs. Ross V. Taylor, Presiding
Memorial Service
Convention Announcements
Report of the Roll Call Chairman
Résumé of County President's Reports
Report of Committee on Resolutions
Unfinished Business
New Business
Report of Committee on Nominations—Mrs. C. I. Owen, Chairman
Election of Officers
Final Report of Registration—Mrs. John Tenhave
Recess
Meeting of the Executive Committee (1963-64)

P.M.

12:30 Inaugural Luncheon — Kent State Room — Pantlind Hotel
"Musical Interlude"
Installation of Officers—National Representative
Presentation of Past President's Pin—Mrs. C. I. Owen
Presentation of President's Pin and Gavel—Mrs. Ross V. Taylor
Inaugural Address—Mrs. R. J. Himmelberger
Adjournment
Post-Convention Board Meeting immediately following adjournment of Annual Meeting in the Kent State Room—Pantlind Hotel—Mrs. R. J. Himmelberger, Presiding

Those who attend:
1963-64 State Officers, District Directors, State Chairmen, County Presidents and Presidents-Elect, Guests

State Society Night

7:00 Cocktails

8:00 Dinner
Guest Speaker: Edward R. Annis, M.D., President of the AMA
Entertainment and Dancing

MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY

Fourteenth Annual Convention

Morton House, Grand Rapids, Michigan

September 25 and 26, 1963

Tuesday, September 24, 1963

P.M.

7:00 Hospitality Room of Morton House, Mezzanine Lobby, Welcoming Committee.
Hostess: Kent County Medical Assistants Society.

Wednesday, September 25, 1963

A.M.

9:00 Coffee Hour—Michigan Medical Service, Mezzanine Lobby.
Registration—Chairman: Mrs. Donna Miller, Mezzanine Lobby.

10:00 "Welcome"—Miss Esther Bartlett, President, MSMAS, Ballroom.
Business Meeting, Ballroom.
Movie for non-members—"Sterilization Procedures in a Doctor's Office." Wyeth Laboratories, Parlors B and C.

P.M.

12:30 Luncheon, Banquet Room.
Hostess: Miss Catherine Hoogenboom.
Speaker: Mrs. Verna M. Armitage, Policewoman, Kent County Sheriff Department. "Children in Problem Environments."

2:00 Howard Blodgett—Grinnell-Row Company, MSMAS Health and Accident Insurance Plan. Ballroom.

2:15 Ralph Blocksma, M.D., "Adventures in Surgery Abroad." Ballroom.

4:00 View Exhibits at Civic Auditorium.

6:30 Social Hour—Courtesy of Medical-Dental-Hospital Business Bureau. Banquet Room.
Hostesses: Mrs. Rose VanSpriel, Mrs. Marian Horning, Miss Judy Smith, Miss Connie Pipe.

7:00 Banquet, Banquet Room.
Hostess: Clella Penner.
Mistress of Ceremonies: Miss Marie Beahan.
Presentation of Medical Assistant of the Year Award.
Presentation of Membership Trophy.
Speaker: Father Hugh M. Beahan, Chaplain, Mt. Mercy Academy, Grand Rapids and Father Michael of popular television program, "Fifteen with Father."

Thursday, September 26, 1963

A.M.

9:00 Coffee Hour—Michigan Medical Service, Mezzanine Lobby.
Registration, Mezzanine Lobby.

10:00 Mrs. Eulodia Sawyer, R.N., Director of Nurses, Mary Free Bed Hospital. Film and narration, "Rehabilitation at Mary Free Bed Hospital." Ballroom

11:00 Charles E. Farber, M.D., and Mrs. Ara Carey, Grand Rapids Child Guidance Clinic. "Emotional Aspects of a Child with a Physical Illness." Panel Discussion with question and answer period.

P.M.

12:30 Presidents' Luncheon, Banquet Room.
Hostess: Mrs. Juanita Ferman.
Recognition of Presidents of each component society.
Installation of Officers.
Presentation of In-service Training Certificates.
Presentation of Charters.
Speaker: Miss Doris VanDellen, Womens' Coordinator of Old Kent Bank and Trust Company, "Madame! What's Under Your Hat?"
Skit: "You Are There," Allegan County Medical Assistants Society.

4:00 View Exhibits at Civic Auditorium.

7:00 Michigan State Medical Society Reception and Dinner. Main Hall, Civic Auditorium, $7.00.

Governor Romney Thanks MSMS For Con-Con Assistance

Dear Michigan Citizens:

Please accept my deepest appreciation for your help in the successful campaign for the new Constitution.

The final margin of victory as determined by the recount clearly revealed the importance of every individual's contribution to the campaign.

Your work and the work of all of those who joined with you comprised the greatest single citizens' effort in Michigan history. The results of this effort will benefit our generation and generations of Michigan residents to come.

Michigan now has one of the finest constitutions in the land, a constitution which has become the envied model for other states to follow. This document will be a lasting tribute not only to the men and women who wrote it, but also to the many people like yourself who won for it a leading role in Michigan's future.

Sincerely,
GEORGE ROMNEY

Lansing, Michigan
July 12, 1963

AMA Journal Article Supports MSMS Views

The five-year MSMS Presidents Program, designed to add years to life and life to years, received encouragement in a recent AMA *Journal* article, April 6, about the work of the AMA Committee on Aging.

To quote only one small portion of the AMA article:

"Question: Why exert these efforts to improve the health of older people in the face of a society that feels they have nothing to offer?

"Answer: This is precisely why the AMA Committee on Aging has tried to encourage a realistic attitude toward aging and the increased capabilities of older people. If these capabilities are not recognized and used, they mean nothing, and they will wither. Health requires not only a sound exercise, nutrition and living program, but a reason for being well.

"A sense of purpose and the opportunity to contribute to others are vital to total health. They can be thwarted by:

"Family members who deny the older member a voice in the family council, who are overly protective and relegate him to the role of puttering.

"The community which refuses to utilize senior citizens' capabilities and the contributions they can make to all aspects of community life.

"Employers who refuse to hire after a certain age or retire persons at an arbitrary chronological age."

Art Work Sought For G. R. Exhibit

In connection with the annual convention of the Michigan State Medical Society in Grand Rapids, September 25, 26, and 27, the Auxiliary to the Medical Society will sponsor an art show featuring the art work of Michigan doctors and their wives.

This will be the third exhibit of its kind in Michigan. These exhibits aroused a great deal of interest among both participants and viewers.

The arrangements and regulations will be simple. The show is to be housed in one end of the scientific exhibit hall in Grand Rapids Civic Auditorium. This plan will enable all those who attend the convention to see the art work without special effort.

Artists should bring their entries (no more than four per artist) to the scientific exhibit hall between 9:30 A.M. and 2:30 P.M., September 24.

Usual care will be exercised in handling all entries, but we cannot assume liability for accidents in handling, breakage or loss by theft. Insurance, if desired, should be carried by the exhibitor.

Gerald Mast, art instructor for the University of Michigan Extension Program in Grand Rapids, will judge the exhibit.

Awards will be made in the following categories:

1. Painting: Oil, encaustic, lacquer, polymer, et cetera
2. Painting: Water color, casein, tempera, gouache
3. Sculpture: Wood, metal, stone, ceramic
4. Ceramics
5. Drawing, graphic art, prints
6. Three dimensional design, weaving

Further information can be obtained from the Art Exhibit Chairman, Mrs. R. A. Rasmussen, 2630 Middleboro Lane N.E., Grand Rapids 6, Michigan.

Michigan Medical Meetings

MSMS House of Delegates, September 22-23-24, Grand Rapids

Michigan Medical Service annual meeting, Grand Rapids, September 24

Woman's Auxiliary of Michigan State Medical Society annual meeting September 24-26, Pantlind Hotel, Grand Rapids

Michigan State Medical Society Annual Session, September 25-27, Civic Auditorium—Pantlind Hotel, Grand Rapids

Michigan State Medical Assistants Society annual meeting September 25-26 at Morton House, Grand Rapids

Midwest Regional Group of Medical Library Association, October 3-5, Bronson Hospital, Kalamazoo

Hospital Section of Michigan Library Association, October 18, Bancroft Hotel, Saginaw

Alumni Conference, Michigan Medical Center, October 18-19, Ann Arbor.



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain... not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

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CSO-9193

Welcome, New Members

Ana G. Alvarez, M.D.
Detroit Memorial Hospital
Detroit 26, Michigan

Constantine T. Anastassiadis, M.D.
10030 Cadieux
Detroit 24, Michigan
Internal Medicine

Jerry W. Anderson, M.D.
1716 Glastonbury Rd.
Ann Arbor, Michigan
Internal Medicine

Emily A. Bandera, M.D.
2800 Plymouth Rd.
Ann Arbor, Michigan
Internal Medicine

Henry A. Boldt, Jr., M.D.
1025 David Whitney Bldg.
Detroit 26, Michigan

David N. Cheris, M.D.
1108 Maiden Lane Ct.
Ann Arbor, Michigan
Roentgenology-Radiology

Thomas N. Cross, M.D.
NPI-OPD University Medical Center
Ann Arbor, Michigan
Psychiatry

Raymond E. Culver, M.D.
1222 Elbridge Pl.
Ypsilanti, Michigan
Gastroenterology

Robert E. Damiano, M.D.
Upjohn Company
301 Henrietta St.
Kalamazoo, Michigan

Arthur D. Ericsson, M.D.
Dept. of Neurology
University Medical Center
Ann Arbor, Michigan
Neurology

James Gordon, M.D.
102 N. Fourth St.
Ontonagon, Michigan

Joseph G. Gough, M.D.
3423 Edgewood
Ann Arbor, Michigan
Physical Medicine

James A. Hagans, M.D.
Upjohn Company
301 Henrietta St.
Kalamazoo, Michigan

Samuel P. Hicks, M.D.
1112 Meadowbrook
Ann Arbor, Michigan
Pathology

Marvin R. Jewell, M.D.
Children's Hospital
Detroit 2, Michigan
Anesthesiology

Richard D. Judge, M.D.
Heart Station
University Medical Center
Ann Arbor, Michigan
Cardiovascular Diseases

Paul A. Kelley, M.D.
2513 Hampshire
Ann Arbor, Michigan
Orthopedic Surgery

Hyman Kurtz, M.D.
13087 E. Eleven Mile Rd.
Warren, Michigan
General Practice

Richard Komisaruk, M.D.
1025 E. Forest
Detroit 7, Michigan
Psychiatry

George A. Lewis, M.D.
Ypsilanti State Hospital
Ypsilanti, Michigan
Internal Medicine

W. Carter Lowe, M.D.
Bronson Medical Center
252 E. Lovell St.
Kalamazoo, Michigan

Harry R. McFarland, Jr., M.D.
208 N. Division
Ann Arbor, Michigan
Neurology

John T. McGreer, III, M.D.
1821 Covington
Ann Arbor, Michigan
Roentgenology-Radiology

Barbara A. Mella, M.D.
721 S. State St.
Ann Arbor, Michigan
Resident in Neurology

Vytautas Mileris, M.D.
2730 E. Jefferson Ave.
Detroit 7, Michigan

Normand Naumoff, M.D.
Detroit Memorial Hospital
Detroit 26, Michigan

Gilbert M. O'Gawa, M.D.
Henry Ford Hospital
Detroit 2, Michigan

Richard J. O'Malley, M.D.
230½ W. Main
Ionia, Michigan

Frank Olney, M.D.
Leonidas, Michigan

Maurice S. Pelto, M.D.
2226 Parkwood
Ann Arbor, Michigan
Roentgenology-Radiology

John F. Plant, M.D.
2909 E. Grand River
Lansing, Michigan
Ophthalmology

Andre's Resto Soto, M.D.
17644 W. Warren
Detroit 28, Michigan
Surgery

Louis S. Sanford, M.D.
Wortley Building
Belding, Michigan

Heinz R. Schroeder, M.D.
Wayne County General Hospital
Eloise, Michigan
Psychiatry

Thomas T. Skrentny, M.D.
1411 Pear St.
Ann Arbor, Michigan
Research

Allen R. Soble, M.D.
18241 Greenfield
Detroit 35, Michigan

James Stanton, M.D.
225 S. Gratiot
Mt. Clemens, Michigan

Robert E. Stevens, M.D.
316 W. Davis
Ann Arbor, Michigan

George J. Straschnov, M.D.
33020 Palmer
Wayne, Michigan
Orthopedic Surgery

Joseph J. Tiziani, M.D.
Box A
Ypsilanti, Michigan
Psychiatry

Ronald E. Trunsky, M.D.
Sinai Hospital
Detroit 35, Michigan

Richard M. Van Schoick, M.D.
300 Wilton
Ann Arbor, Michigan
Pediatrics

Ross Vilardo, M.D.
54 Roosevelt Avenue
Hasbrouck Heights,
New Jersey

Wallace C. Weckesser, M.D.
1602 Military
Port Huron, Michigan

John E. White, M.D.
2931 Burlington Court
Ann Arbor, Michigan
Neurological Surgery

Kenneth R. Wilcox, Jr., M.D.
Michigan Dept. of Health
35 N. Logan St.
Lansing, Michigan
Public Health

John N. Wolfe, M.D.
432 E. Hancock Avenue
Detroit 1, Michigan
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ROBAXIN (methocarbamol) relaxes painful skeletal muscle spasm without impairment of normal muscle strength or neuromuscular function.

Side effects, such as lightheadedness, dizziness, drowsiness, and nausea, may occur rarely, but usually disappear when dosage is reduced. Hypersensitivity reactions have been reported infrequently. Contraindicated in patients hypersensitive to the drug.

Average adult dose

	ROBAXIN® (methocarbamol, 500 mg./tab.)	ROBAXIN®-750 (methocarbamol, 750 mg./tab.)
Initially	3 tablets q.i.d.	2 tablets q.i.d.
Maintenance	2 tablets q.i.d.	1 tablet q.4 h. or 2 tablets t.i.d.

A. H. ROBINS CO., INC., Richmond 20, Virginia


There's nothing like a vacation*
for relaxing stress-induced smooth muscle spasm...

Outstanding effectiveness in clinical usage—plus freedom from the risk of serious side effects—are the compelling reasons why DONNATAL has maintained its pre-eminent position as a smooth muscle relaxant through the years.

Over 5 billion doses have been administered since its introduction...impressive evidence of professional confidence in the clinically reported benefits provided by DONNATAL:

- excellent results in a wide range of visceral disorders[1-6]
- well tolerated[1-6]
- convenient dosage forms[1,3]
- uniform composition[1,3]
- stability[1,3]
- economy[1,3]

DONNATAL is indicated in recurring, persistent or chronic visceral spasm, as in: peptic ulcer, pylorospasm, irritable stomach and colon, nervous indigestion, dysmenorrhea, nausea of pregnancy, motion sickness, nocturnal enuresis, mucous colitis and diarrhea.

No serious toxic reactions are to be anticipated. Dryness of the mouth, blurred vision, difficult urination, and flushing and dryness of the skin may occur with excessive and prolonged dosage, but promptly disappear with reduction in dosage.

DONNATAL is contraindicated in acute glaucoma, advanced hepatic or renal disease, and known or suspected idiosyncrasy to any of its components. Patients with incipient glaucoma or urinary bladder neck obstruction must be treated with care, as with any preparation containing a parasympathetic depressant.

REFERENCES: **1.** Barden, F.W., Hill, P.S., Mahaney, W.F., and Cuneo, K.J.: J. Maine M.A. 45:11, 1954. **2.** Chaput, Y., and Baillargeon, J.: L'Union med. du Can. 86:205, 1957. **3.** Hock, C.W.: Clin. Med. 8:1932, 1961. **4.** Kilstein, R.I.: Rev. Gastroenterol. 14:171, 1947. **5.** Marks, L.: Am. J. Gastroenterol. 27:180, 1957. **6.** Wharton, G.K., Balfour, D.C., Jr., and Osmon, K.L.: Postgrad. Med. 21:406, 1957.

nothing, [illegible] sedative-antispasmodic action of

Donnatal®

Robins

In each Tablet, Capsule or 5 cc. Elixir		In each Extentab
0.1037 mg.	hyoscyamine sulfate	0.3111 mg.
0.0194 mg.	atropine sulfate	0.0582 mg.
0.0065 mg.	hyoscine hydrobromide	0.0195 mg.
16.2 mg. (¼ gr.)	phenobarbital (¾ gr.)	48.6 mg.

(Warning: May be habit forming)

Prescribed by more physicians than any other antispasmodic—*well over 5 billion doses!*

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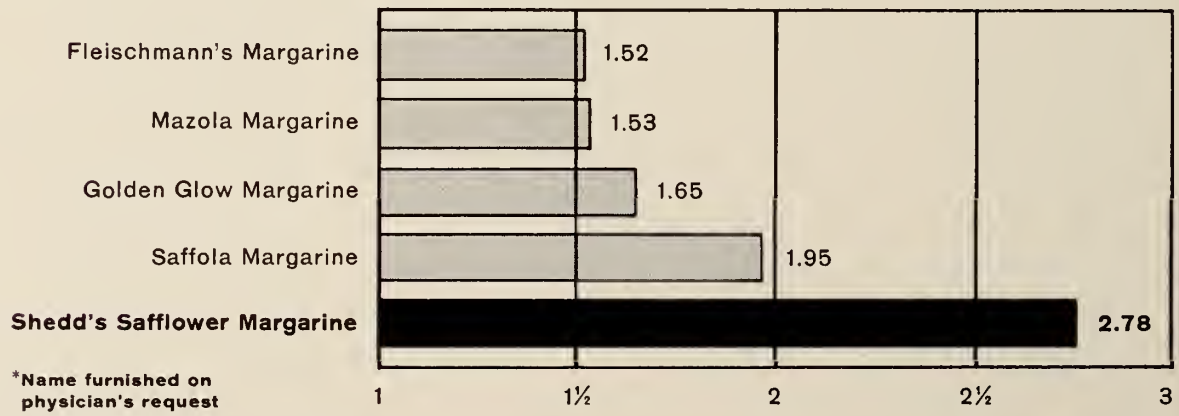


RATED BEST!!

in ratio of poly-unsaturates to saturated fats

An outstanding, independent research laboratory* was asked to compare five leading margarines for their proportions of beneficial poly-unsaturates to saturated fats. All samples were purchased at store level by shoppers for the research laboratory, and the results given are the average of two tests made on each margarine.

THE RESULTS OF THIS TEST PROVED SHEDD'S SAFFLOWER MARGARINE HAS A HIGHER RATIO OF POLY-UNSATURATES TO SATURATED FATS.



*Name furnished on physician's request

Shedd's Safflower Margarine Tastes Best, too!

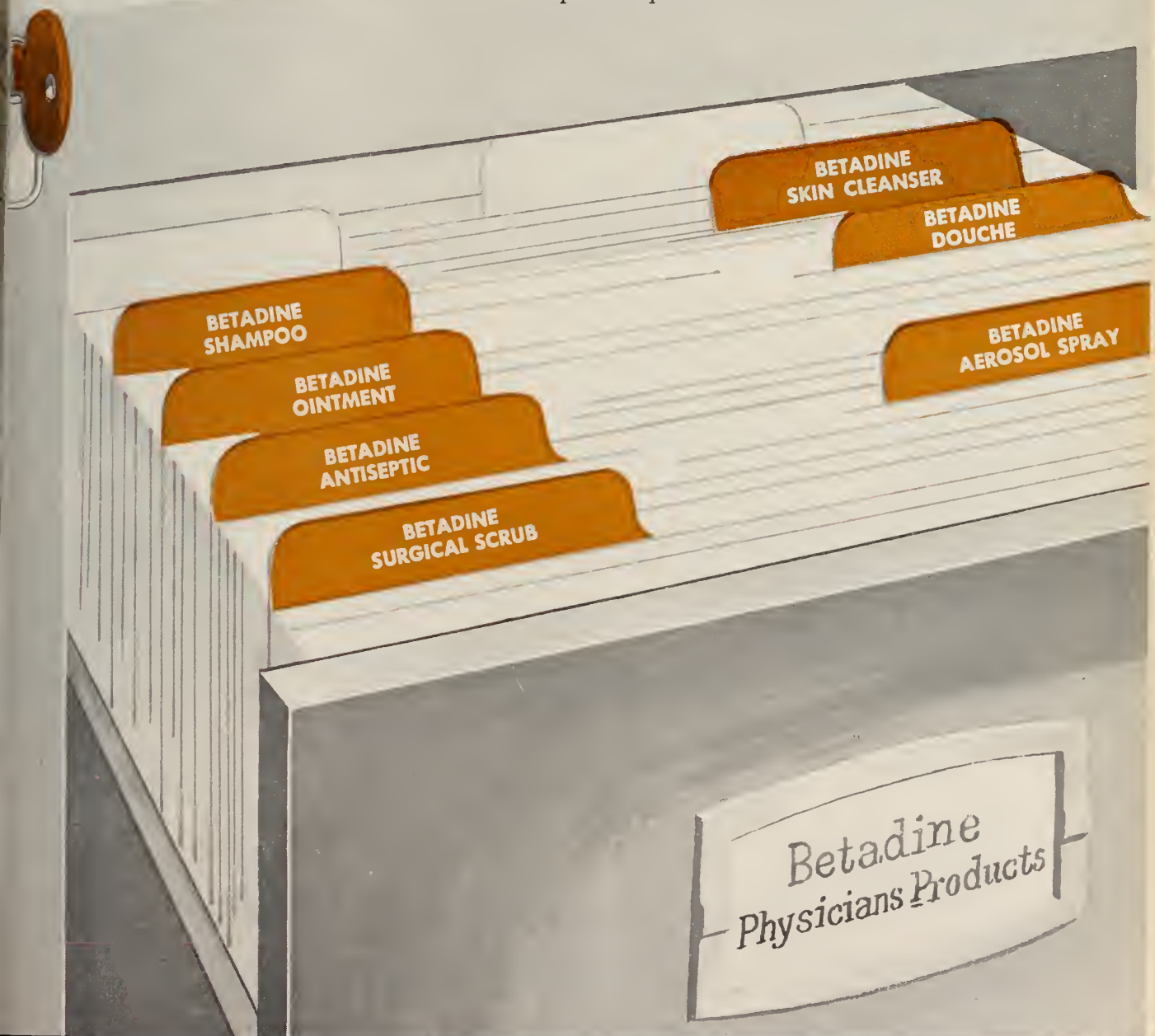
NOTE TO DOCTORS: For free physician's certificate just send your request to Shedd-Bartush Foods, Inc., Detroit 38, Mich. on your Rx form.

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roducts
lock a wide
nge of usefulness

Betadine Products, in all seven dosage forms, contain povidone-iodine, a complex of polyvinylpyrrolidone and iodine, providing all the germicidal properties of elemental iodine . . . yet Betadine (povidone-iodine) is nonirritating, nonsensitizing, and nontoxic to skin or mucosa.

Betadine Products are effective in preventing and treating a variety of infections frequently encountered in the practice of otolaryngology, orthopedics and orthopedic surgery, obstetrics and gynecology, oral surgery, pediatrics, surgery and dermatology.

The clinical results reported under various conditions of use make Betadine (povidone-iodine) preparations valuable adjuncts both in the hospital and in private practice. Literature available upon request.



PHYSICIANS PRODUCTS CO., INC.
PETERSBURG, VIRGINIA



Helps speed recovery even in severe muscle injuries

Whether your muscle-injury patient is a professional athlete or just a weekend golfer, you can expect rapid results with 'Soma' (carisoprodol).

This unique drug breaks up both muscle spasm and pain at the same time. Onset of action takes only 30 minutes, and your patient will usually begin to feel better within hours.

As Conant demonstrated in a study of 106 patients with musculoskeletal injuries, 88% of the patients treated with 'Soma' (carisoprodol) achieved good to excellent results. *(Clinical Medicine*, March, 1962.)

Carisoprodol seldom produces side effects. Occasional drowsiness may occur, usually at higher than recommended dosage. Individual reactions may occur rarely.

For severe athletic strains or everyday sprains, you can rely on 'Soma' (carisoprodol) to help speed recovery with notable safety.

USUAL DOSAGE: ONE 350 MG. TABLET Q.I.D.

The muscle relaxant with
an independent pain-relieving action

Soma®
carisoprodol

Wallace Laboratories, Cranbury, New Jersey

Wayne Doctors Conduct "Immunization Month"

During "Immunization Month" promoted by the Wayne County Medical Society, a total of 26,600 "shots" were administered at special clinics throughout the county.

Precise figures are not available concerning the number who have received inoculations from their private family physician during June, but spot checking of MD offices by the County Medical Society indicated a highly favorable patient response.

Vaccines providing protection against smallpox, tetanus and polio are being offered to adults. Children receive diphtheria and pertussis, in addition to the above-mentioned vaccines.

More than 180 doctors volunteered their services to staff immunization clinics in Wayne County during June.

Co-sponsors of the Wayne County project were the Wayne County Department of Health and the Detroit Department of Health.

* * *



Kalamazoo Assists Goodwill

The Kalamazoo Academy of Medicine, as a community-service project, sponsors a Goodwill Pick-Up Box, located at the Southland Shopping Center in Kalamazoo.

Mason Offers Aid Course

The Mason County Medical Society and the Zonta Club are cooperating to conduct a Medical Self-Help Course at Ludington. Robert R. Garneau, M.D., Manistee, spoke at the opening session.

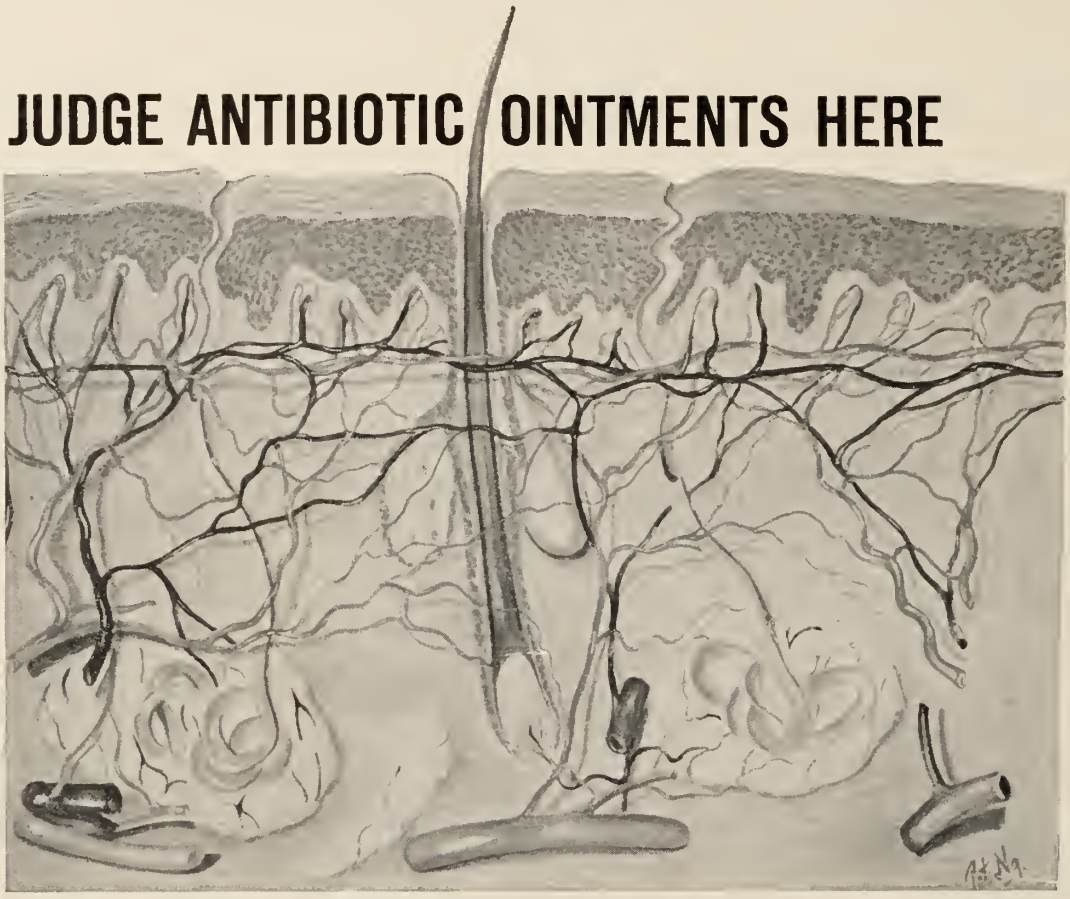
Calhoun Helps Students

There were many highlights to the annual Health Career Day sponsored recently at Battle Creek by the Calhoun County Medical Society and the Calhoun County Unit of the American Cancer Society.

Richard J. Campbell, M.D., president of the County Society, announced the establishment of a $200 Stuart Pritchard Memorial Scholarship for county high school students planning to enter the practice of medicine. Doctor Pritchard was the first president of the W. K. Kellogg Foundation.

Special recognition was given to 46 honored guests—including 14 doctors of medicine, for devoted service. Each received a "Certificate of Merit."

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Antibiotic Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and rarely sensitizes.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®
brand

POLYMYXIN B-BACITRACIN-NEOMYCIN ANTIBIOTIC OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Greeting Your Patients



A businessman who went to see his doctor recently wrote:

"I entered a deserted waiting room. There was no receptionist. The only indication of human habitation was a placard on a doorknob stating that 'Doctor Is In.' So I sat down, wondering whether I should make my presence known. But how? Should I go over to the door and knock or open it a crack?

"I picked up a magazine but could not concentrate. My irritation was growing. I waited ten minutes, wondering how the doctor would know I had arrived. Another ten minutes passed—by that time I felt like the forgotten man!"

This treatment does not endear a doctor to his patient. If you do not have a receptionist, why not place a register in your reception room with a sign above it, clearly saying, "Please sign the register when you arrive. Doctor will see you shortly." Or, "Please ring the bell for the receptionist and be seated. The doctor will see you in a few minutes." The patient is immediately reassured—he is expected.

If you employ a girl who greets your patients, train her in the art of welcoming them. Place her desk so that she can see all newcomers, yet converse with patients with some degree of privacy.

Patients have a right to expect courtesy in the doctor's office. They have come, as consumers, ready to purchase medical service. Each person should be greeted not only with courtesy but with friendliness. Rich or poor, every patient should be treated with the same consideration and recognized as an individual.

When your receptionist greets patients, she can use a typical welcome: "Good morning, Mrs. Smith. You are right on time! The doctor will see you in just a few minutes. Won't you sit down? There are some new magazines on the table. . . ."

When the doctor is ready to see Mrs. Smith, the receptionist should usher her into his office. If she is a new patient, introductions should be made, just as if a guest were being introduced to a host. Make sure you get the name right. Nothing is more irritating than having your name mispronounced.

When there is no receptionist, the doctor himself must assume the full responsibility for greeting his patients. After checking his appointment book to determine who is next on his schedule, he can step to the door of his waiting room and with a friendly smile announce the patient's name in such a way as to indicate a greeting and that you are now ready to see her.



For dramatic restoration

WINSTROL®

brand of STANOZOLOL

Oral anabolic therapy with this new physiotonic helps restore the patient's: positive protein metabolism; confidence, alertness and sense of well-being.

WINSTROL (stanozolol/Winthrop), a heterocyclic steroid, combines highest potency* with outstanding tolerance, stimulates appetite and promotes weight gain... restores a positive metabolic balance. It counteracts the catabolic effects of concomitant corticosteroid or ACTH therapy. WINSTROL (stanozolol/Winthrop) rebuilds body tissue while it builds strength, confidence and a sense of well-being in conditions associated with excess protein breakdown, insufficient protein intake and inadequate nitrogen and mineral retention.

Side Effects and Precautions: Prolonged administration can produce mild hirsutism, acne or voice change. In an occasional patient, edema has been observed and in young women the menstrual periods have been milder and shorter. These side effects are reversible, and patients receiving prolonged treatment should be examined and questioned periodically so that, should side effects appear, the dosage may be reduced or administration of the drug discontinued for a time.

In patients with impaired cardiac and renal function, there is the possibility of sodium and water retention. Liver function tests may reveal an increase in bromsulphalein retention, particularly in elderly patients. In such cases, therapy should be discontinued. Although it has been used in patients with cancer of the prostate, its mild androgenic activity is considered by some investigators to be a contraindication.

Dosage: Usual adult dose, 1 tablet t.i.d. before or with meals; young women, 1 tablet b.i.d.; children (school age): up to 1 tablet t.i.d.; children (preschool age): ½ tablet b.i.d. Available as scored tablets of 2 mg. in bottles of 100. For best results, administer with a high protein diet.

Rx WINSTROL *ANIMAL DATA
(stanozolol/Winthrop) whenever anabolic therapy is indicated

Winthrop

Winthrop Laboratories, New York 18, New York

Say you saw it in the Journal of the Michigan State Medical Society

there is nothing "new" about Thorazine®



brand of
chlorpromazine

In the nine years since it became available to American physicians, Thorazine (chlorpromazine, SK&F) has been more widely used, more thoroughly investigated and more extensively documented than any other agent of its type.

Its actions, effects—and side effects—are well known throughout the medical profession. Its efficacy has been clearly demonstrated. And when properly used, its advantages far outweigh any possible disadvantages.

This is why there is nothing "new" about Thorazine (chlorpromazine, SK&F). This is why it remains the first choice in many conditions—and the standard against which other agents are inevitably compared.

This is why it is one of the fundamental drugs in medicine.

SMITH KLINE & FRENCH
LABORATORIES, PHILADELPHIA

SK&F

Abscess
Acne
Amebiasis, acute, intestinal
Anthrax
Bacillary dysentery
Bacteremia
Bartonellosis
Bronchitis, acute
Bronchopulmonary infection
Brucellosis, acute
(IN COMBINATION WITH OTHER ANTIMICROBIAL AGENTS)
Chancroid
Diphtheria
(IN CONJUNCTION WITH ANTITOXIN AND ROUTINE ESTABLISHED THERAPY)
Endocarditis, subacute, bacterial
Genitourinary infection
Gonorrhea
Granuloma inguinale (DONOVANOSIS)
Infections associated with pancreatic fibrosis
Listeriosis
Lymphogranuloma venereum
Meningitis, purulent
Mixed bacterial infection
Osteomyelitis
Otitis
(EXTERNA OR MEDIA)
Pertussis
Pharyngitis
Pneumonia
(WITH OR WITHOUT BACTEREMIA)
Psittacosis
Pyelonephritis, acute and chronic
Rocky Mountain spotted fever
Scarlet fever

proven effective in over

50

disease entities...

Septicemias
(STAPHYLOCOCCAL AND PNEUMOCOCCAL)
Sinusitis
Soft tissue infections
Tonsillitis
Tularemia
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Urethritis
(NONGONOCOCCAL)
associated with tetracycline-sensitive microorganisms, the more important of which are:
STREPTOCOCCI
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PNEUMOCOCCI
GONOCOCCI
SHIGELLAE
RICKETTSIAE
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and, in particular, with certain species of tetracycline-sensitive microorganisms such as the following:
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DIPLOCOCCUS PNEUMONIAE
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Surgical and dental preoperative and postoperative prophylaxis
Syphilis
(WHERE THE PATIENT IS PENICILLIN-SENSITIVE)
Typhoid fever
(WHEN CHLORAMPHENICOL IS CONTRAINDICATED)
Agammaglobulinemia or hypogammaglobulinemia and recurring infections
(WITH CAMMA CLOBULIN THERAPY)

ACHROMYCIN® V

TETRACYCLINE HCl WITH CITRIC ACID

SIDE EFFECTS (infrequent and usually mild): glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. CONTRAINDICATIONS: None, but the following precautions should be observed: high-calcium-content foods or drugs should not be taken for at least one-half hour after each dose; avoid excessive accumulation of antibiotics by reducing dosage in patients with impaired renal function; consider possibility of discoloration of teeth during tooth development (late pregnancy, infancy or early childhood).
CAPSULES—250 mg. and 100 mg.; SYRUP; PEDIATRIC DROPS.

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Tax Deductions On Health Costs

By Richard M. Campau

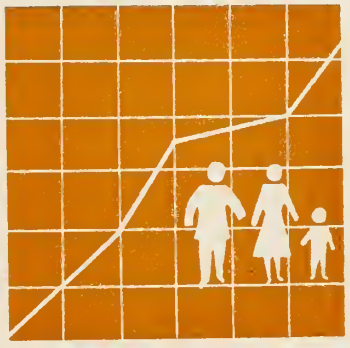
MSMS Research Director

Recent data released by the Internal Revenue Service indicates that one out of every four American families have "extraordinary" medical and dental expenses in a given year. "Extraordinary" is defined as that amount which exceeds 1 per cent of income for medicine and drugs and everything over 3 per cent of income for medical and dental expenses. Among 61,027,931 total returns, 14,865,460 taxpayers claimed medical and dental deductions. They spent $8,595,130,000, of which $5,219,185 was allowed as a tax deduction after the required write-off of 1 per cent of income for drugs and 3 per cent for all medical and dental expenses.

The chart below details health care expenditures of these same taxpayers by various income strata.

Additional IRS data shows taxpayers with deductions for health costs deduct an average of 3 per cent of adjusted gross income for their medical needs.

This compares with average contributions of 3.7 per cent of income for church and charities; 4.7 per cent of income for interest payments on mortgages and other loans; 5.8 per cent of income for taxes and fees and 2.4 per cent of income for miscellaneous deductible expenses.



Health Insurance Coverage Up in '62

More than 141 million Americans—76 per cent of the civilian population—had some form of health insurance at the end of 1962. The Health Insurance Council reports that both the number of persons covered and the amount of benefits paid by health insurance reached new highs last year. Coverage increased 4.6 million during 1962 to reach a total of 141,151,000.

Benefit payments by all health insuring organizations to help cover the cost of hospital, surgical and medical care amounted in 1962 to nearly $6.2 billion, up $629 million over 1961, said the Council. In addition, persons with loss-of-income policies received $906 million in benefits from insurance companies to replace income lost through disability. Thus, a grand total of $7,077,000,000 in health insurance benefits was distributed during 1962, up 10.6 per cent over 1961.

	Health Expenditures		*Average Expenditures*			
Income	*Total*	*Deductible Amount*	*Drugs*	*Medical and Dental*	*Total*	*Average Deduction*
$ 600— 2,499	$ 502,760,000	$ 419,192,000	$110	$ 289	$ 360	$ 300
2,500— 4,999	1,967,883,000	1,400,197,000	135	359	455	324
5,000— 7,999	2,900,570,000	1,664,054,000	157	410	523	300
8,000— 9,999	1,052,902,000	544,773,000	184	507	639	330
10,000—14,999	1,006,499,000	526,059,000	216	664	811	424
15,000—19,999	304,913,000	170,738,000	268	950	1,112	622
20,000—24,999	153,151,000	92,956,000	295	1,225	1,392	845
25,000 and Over	507,435,000	230,903,000	349	2,690	2,830	1,288

Source: Statistics of Income . . . 1960, U. S. Treasury Department, Internal Revenue Service
*This is not the sum of drugs and medical and dental since some income tax returns did not have both expenditures.



Protects your angina patient better than vasodilators alone

'Miltrate' contains both pentaerythritol tetranitrate, which dilates the patient's coronary arteries, and meprobamate, which relieves his anxiety about his condition. Thus 'Miltrate' protects your angina patient better than vasodilators alone.

Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma.

Dosage: 1 or 2 tablets *before meals* and at bedtime. Individualization required.
Supplied: Bottles of 50 tablets.

CML-9646

Miltrate®
meprobamate 200 mg.+
pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*

US Spends Millions In Michigan on Health

How much does the federal government spend in Michigan on welfare and health services?

The federal government spent $76.7 million on welware programs in Michigan in 1962 and more than $30.5 million for medical and health services. The figures were reported by Melrose H. Hosch, midwestern regional director in Chicago for the U. S. Department of Health, Education and Welfare.

The 1962 welfare payments included $32,169,000 for old age assistance, $30,830,000 for families with dependent children, $910,000 for aid to the blind, $3,380,000 for the permanently and totally disabled and $9,500,000 for medical assistance to the aged.

Under the category of medical, health and hospital services administered by the HEW department, Mr. Hosch reported these 1962 allotments to Michigan:

$5,242,000 under the Hill-Burton program for construction of hospitals, nursing homes and other medical facilities costing $14,611,000.

$988,000 for maternal and child health services.

$1,214,000 for services to crippled children.

$880,000 for child welfare services.

$540,000 for state and local health programs.

$1,000,000 in grants for services for the chronically ill and aged, mental health programs, and cancer tuberculosis and heart disease control programs.

$950,000 for special nurse and graduate student training programs.

$171,300 for water pollution control.

$12,500,000 for 487 health research projects in public and private institutions and by individual scientists.

$3,764,000 for 99 training grants.

$710,500 for 115 health research fellowships.

$1,603,000 for rehabilitation of 3,741 disabled persons to prepare them for jobs.

$990,000 for rehabilitation training and research grants.

Opposition to "Fedicare" From Businessmen Increases

Opposition among the nation's independent business proprietors to the principle of Medicare financed through Social Security is stiffening, according to the most recent poll of the membership of the National Federation of Independent Business. In balloting conducted in all 50 states, 83 per cent of the small businessmen expressed opposition, and 15 per cent favored the Anderson-King Bill now before Congress, with 2 per cent holding no opinion.

In a vote taken just one year earlier on the same issue, only 77 per cent of the nation's independent entrepreneurs were opposed, with 21 per cent in favor, and 2 per cent undecided.

For your elderly arthritic patients



AN EFFECTIVE GERIATRIC ANTIARTHRITIC WITH DISTINCTIVE SAFETY FACTORS

safely indicated – even when **OSTEOPOROSIS** is present

PABALATE-SF, which has been found "superior to aspirin in the treatment of chronic rheumatic disorders,"[1] possesses distinctive **Safety Factors** for elderly arthritics, even when osteoporosis is present: (1) its potassium salts cannot contribute to sodium retention; (2) its enteric coating assures gastric tolerance; and (3) it does not produce the serious reactions often noted during therapy with steroids or pyrazolone derivatives.

In each persian-rose enteric-coated tablet: potassium salicylate, 0.3 Gm.; potassium para-aminobenzoate, 0.3 Gm.; ascorbic acid, 50 mg.

1. Ford, R. A., and Blanchard, K. P.: J.-Lancet 78:185, 1958.

Precaution: Occasionally, mild salicylism may occur, but this responds readily to dosage adjustment. In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Supply: Bottles of 100 and 500 enteric-coated tablets.

Pabalate®-SF

Robins

(the new, convenient way to prescribe Pabalate-Sodium Free)

A. H. ROBINS COMPANY, INC., RICHMOND, VIRGINIA



We like visitors. We like to show them our modern equipment and latest research facilities, our exacting manufacturing techniques and unexcelled quality standards. Up to a point, that is. A white line provides the barrier that discourages further exploration. It means look but don't cross. It is a safeguard against inadvertent mishandling or misplacing of products—another precaution in an endless list of rules contributing immeasurably to the quality of the finished product.

Eli Lilly and Company • Indianapolis 6, Indiana, U.S.A.

Lilly

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The Medical History of Saginaw

Edward F. Kickham, M.D.
Saginaw, Michigan



PERHAPS it is much too soon to bring forth such an infant onto the stage of medical history, but the command has been given, and the following is a brief chronicle of the events which have occurred in the life of the Saginaw County Medical Society.

Our history begins almost a hundred years ago with a brief note in the *Review of Medicine and Pharmacy* for the year 1866 referring to "a Saginaw Medical Association" which had already been organized at some time prior to that year. We have the testimony of Dr. Lyman W. Bliss in 1896 stating that Saginaw County had maintained a Medical Society "the greater portion of the time since 1866."

There was a clinical organization formed on January 25, 1889, called the Saginaw Valley Medical Club which flourished with a hundred members. It is known that it was successful enough that by the third meeting they had several applicants and speakers from as far as Ann Arbor.

The permanent County Medical Society, however, was organized October 17, 1893, when a meeting was held in response to a call issued by Drs. J. J. McLaren, S. C. Ostrom, and George C. Schemm. With about 10 physicians present, Dr. Chester H. Sample was elected president and by 1897 there were 40 members out of about 100 physicians in the area at the time.

The earliest recorded minutes in the possession of the present Society are dated September 1, 1902, the meeting being called to order by President Henry J. Meyer at Recorder's Office, City Hall. The business was to form a committee for the drafting of a constitution and by-laws for re-organization of the Saginaw County Medical Society.

This was accomplished by the next meeting September 19, 1902, and the Michigan State Medical Society gave the Saginaw County Medical Society its charter on October 14, 1902, the application form being signed by President Meyer. It is interesting to note that Doctor Meyer is still active and was of great help in developing this paper.

At the meeting of October 6, 1902, Dr. Williamson was elected President and the following minutes speak for themselves:

"Doctor Meyer moved that President and Secretary be appointed a committee to confer with a committee from Homeopathic Society to take such steps as they may deem necessary to stop irregularities in practice and to prevent those who are not legally registered from doing business in Saginaw County. Motion supported and carried. Moved by Dr. D. B. Cornell that above committee interview the Democratic candidate for Prosecuting Attorney and ascertain his views regarding prosecution of violators of the State Medical Act and, if he be not favorably inclined to do his duty in this matter, that the Secretary notify all members of this Society to that effect. Motion carried."

It is quite evident from the action taken in these early meetings that the tenor was towards vigorous and active participation in medical and community affairs. This has also been true of this Society in subsequent decades.

Some of the pioneers in Saginaw Medicine should be mentioned at this point, the first one being Dr. J. J. Jerome who was a graduate of Geneva Medical College in New York and was professor of anatomy for many years. He then moved to Saginaw and was twice elected President of the State Medical Society (1867 and 1881). Another figure of the day was Dr. J. B. White, who was not only an outstanding doctor, but also served as County Sheriff. It is known that there were 30 doctors in Saginaw County in the year 1866, and before that nothing much is known.

The founding of the hospitals in the area is an absorbing chapter, starting with St. Mary's Hospital under the direction of the Daughters of Charity in 1874. The prime mover and leading physician of that time was Dr. Benjamin B. Ross, a pugnacious but very gifted surgeon who enlisted the citizens in the procuring of the hospital. At that time, the lumbering era was in full swing, and there were numerous casualties among the thousands of men engaged in the business.

Following the erection of St. Mary's Hospital, the Sisters went out to the lumbering camps to obtain funds by selling sick benefit tickets for $5, providing the holder to use the hospital for one year during illness or accident. These hospital certificates were sold for 22 years and were a true form of pre-paid medical insurance which was very satisfactory for both the patients and the hospital.

Doctor Ross was the great industrial surgeon of the day, serving all the great saw mills which lined the river and provided a great array of injuries.

It was inevitable that a strong character such as Doctor Ross would run afoul of Dr. Lyman W. Bliss, who became his chief antagonist. Doctor Bliss graduated from Hobart College, Geneva, New York, and saw active service in the Civil War. He located in Saginaw in 1866 and became a President of the Michigan State Medical Society as well as the first and only president of the Saginaw Valley Medical College.

Doctor Bliss was also a strong character and had his own ideas as to how medicine in Saginaw should be run. He was mayor of Saginaw City in 1888, and at that time plans were being made to erect Saginaw General Hospital. He insisted that no East Side physicians should become members of the staff, and when overruled on this point, he established a hospital of his own—the Bliss Hospital.

As an indication of the times, the story is told that following his election as President of the Michigan State Medical Society in 1890, Doctor Bliss saw to it that Doctor Ross was expelled from the Society on the grounds that he had consulted with a homeopath. The following year, an effort was unsuccessfully made to turn the tables on Bliss when the Ross faction charged Bliss with performing a criminal operation. At the State Society meeting, which was held that year in Saginaw, the Society refused to act on the charge.

The organization of the Saginaw Valley Medical School would probably be considered our greatest claim to fame. This institution opened in 1896 and remained in operation until 1903, being founded by Dr. J. L. McLaren, Dr. D. B. Cornell and William Heim, druggist. The College opened with 65 students, the faculty working without pay, depending on the graduates to reward them by referring patients.

Dr. William J. O'Reilly has described very vividly the various men who were on the faculty of the Old Medical College, and we are indebted to Dr. Rockwell Kempton's painstaking notes regarding the word pictures of these doctors. Here are a few of the descriptions as he gave them.

Dr. D. B. Cornell—An EENT specialist who located in Saginaw in 1889 and was the spark plug of the College. He had charge of all financial matters in connection therewith.

Dr. O. P. Barber—A gifted surgeon who had a high grade clientele and did much to give the College prestige in the community. He was the outstanding after dinner speaker in Saginaw. Also he was quite a wit as noted in this incident. He met one of his colleagues and handed him a $5 bill. The other doctor took it, thinking it was a consultation fee, and asked by whom it was paid. The sharp reply was, "Any doctor who steals patients must be considered an object of charity. Keep the money."

Dr. B. B. Rowe—Fresh from his surgical training at Ann Arbor, he impressed the students so favorably

that he profited most from having patients referred to him by the graduates.

Dr. S. C. J. Ostrom—Very oratorical, he held the interest of the students while lecturing on a dry subject by relating humorous anecdotes of which he had a large fund.

Dr. G. W. Stewart—Having a large private obstetrical practice, he was frequently called into consultation by other physicians in cases of difficult delivery.

Dr. Henry J. Meyer—Graduated from the Detroit College of Medicine and was an interne at Harper Hospital in 1897. He taught anatomy for three years and surgery for two years at the College. Doctor Meyer recalls that Doctor Barber, who was a huge man, had outsized tires on his rig so that he could ram wheels with Dr. Lyman W. Bliss who was the College President. Doctor Meyer inadvertently became the x-ray man when the technician left town. He recalls that the machine was in pieces and after painstakingly reconstructing it, he had his first case, which was a dislocated shoulder, on which to test the machine. The drapes were drawn and the lights put out, after which the machine was turned on with an audience of many students. In the darkness, the blue flames threw an eerie light around the room and finally the picture was snapped only to have the machine blow up with a loud crash. The patient and the students disappeared at full gallop, leaving Uncle Henry with a singed mustache. He later found that the janitor had put kerosene instead of oil in the breaker box and a spark had set this off.

In a recent conversation, Doctor Meyer confirmed this story and with the true curiosity of the physician he said, "You know, I never did see that patient again. His shoulder was still dislocated when he left."

The height of prosperity from the lumber industry was in 1890, at which time the population was 60,000. Next came the depression of 1898, and there was the development of coal mines shortly thereafter. This introduced contract medicine through Doctor Linton, who was the mine doctor. This type of medicine was later condemned by the Society.

From the period 1890 to the First World War, there was a transition in medicine and surgery with the development of aseptic technique.

Dr. H. M. Leach is credited with bringing the advances of Lister to the Saginaw Valley, thus opening the way for modern surgery. He was a fierce drinker, but a fine surgeon. It is recalled by Doctor Meyer that the first operating table at St. Mary's Hospital was a leather couch, and he remembers when one of the sisters came back from a meeting in Chicago with the advanced idea of bandaging the doorknobs in the surgery with gauze.

It is interesting to note that Saginaw General Hospital provided ward care for $5 a week, including medical attention and nursing following its opening in 1889.

The Woman's Hospital opened in 1890 to care for women only and in particular for sick, unfortunate girls who had been driven from home and society. Mrs. Dr. E. J. Freeman was the driving force in this endeavor. Several years later, when it was about to close, it was taken over by Lutheran Charities and is now the modern St. Luke's Hospital.

The open warfare which existed among physicians near the turn of the century gave way to kindness and cooperation in later years, as evidenced by many subsequent events. For example, we note the adoption of a plan for aiding the families of doctors entering service during World War I. It was decided in the meeting of July 2, 1917 that an assessment of not less than $10 a month be made on all men in active practice, starting when the first married medical men were called into service. This money was to be used in monthly installments to be given to the families of these service men, in amounts not over $500 yearly.

In the depression years of the '30s, there were exemplary cooperative efforts made to care for the indigent people of the county. We read in the minutes of the September 1931 meeting a proposal by Dr. Stuart Yntema regarding the care of indigent cases in the County Contagious Hospital. This plan provided for a contract with the County Board of Supervisors to do this work for an annual sum of $3600. The Society agreed to have three men on call at all times and to provide daily visits by a doctor at the hospital. In practice, it was decided to have doctors attend the patients in 10-day shifts. The money was to be divided equally among all members participating. The following year, this plan was extended to include an agreement for treatment of all indigent patients admitted to the three hospitals (Saginaw General, St. Luke's and St. Mary's); the fees then being paid directly to the Treasurer of the Saginaw County Medical Society. The fee was computed on the basis of 25% of the hospital bill for each patient.

These plans functioned successfully for many years and have resulted in a surplus fund in the Treasury of the Society which is still held for some general purpose such as helping to build a permanent home for the Society.

However, in 1937 the Report of the Medical Advisory Committee of the Saginaw County Contagious Hospital headed by Dr. Walter Slack states:

"The enthusiasm and spirit of cooperation of the physicians toward the hospital (County Contagious), which previously were so excellent, has entirely disappeared. I know of no way to revive it under present conditions. Inasmuch as we can obtain no contract with the County nor a definite reason for the delay, it is my personal opinion that the medical society should demand a contract by January 1, 1938 or their work in the hospital as a unit cease. Personally, I feel that this is what is desired."

Thus, with the end of the depression ended the great experiment.

At about this same time, however, another cooperative effort of a purely medical nature was developed and it has survived and grown to the present day. This was the concept of a Central Hospital Credentials Committee designed to standardize the practice of surgery and obstetrics by recommending individuals for surgical practice in Major and Lesser Major categories. The original chairman of the organization was Dr. Clarence Toshach, and the permanent members have been Dr. William K. Anderson (roentgenologist) and Dr. Oliver W. Lohr (pathologist). The story of this so-called "Saginaw Plan" is presented elsewhere in this JOURNAL and is mentioned here only for chronology.

With the 1940s, we reach the World War II period of modern history and perhaps with Wendell Phillips we might now say, "But, fifty years hence when Truth gets a hearing, the muse of history" will be more objective. However, there are a few names and events which come to mind and should be included here.

On November 12, 1940 was held the first Industrial Medical Conference sponsored by any local medical society in the U.S.A. The credit for this event goes to Dr. Richard D. Mudd who has been the father of Industrial Medicine in this area. He might also be remembered as the brilliant apologist for another famous physician, Dr. Samuel Mudd, whose name has been cleared of involvement in the crime of John Wilkes Booth.

Another event of importance in 1940 was a Testimonial Dinner in honor of Dr. William J. O'Reilly on the occasion of his 50th year of practice. He was always the final authority on questions of parliamentary or medico-legal problems, and while many suspected that he often made up a rule to fit the situation, his word was always accepted as law. His memory of early medicine in Saginaw has been set down in the Kempton papers and is the basis for our knowledge of the old medical school.

Mention should be made of some of the still active members who have contributed much to the medical history of the area. The first name which comes to mind is that of Dr. Oliver W. Lohr who came to Saginaw in 1922 and has been on the dead run for forty years, half the time as the only pathologist in the area. He was in the thick of the fight for pure water and pasteurized milk which was successful in 1929. He deserves a great deal of credit for the fact that Saginaw had the lowest mortality rate of any city its size during the meningitis epidemic. During the past few years, Doctor Lohr has concentrated on his hobbies of photography, polishing stones, traveling and collecting. Within the past year, he has received a present from the Shah of Iran and has been the subject of a television interview. His enthusiasm continues undimmed. Serving with Doctor Lohr on the Central Credentials Committee as its permanent secretary for 25 years has been Dr. William K. Anderson who came to Saginaw in 1925, the first trained radiologist. Doctor Lohr states that x-rays were sent to Detroit from Saginaw when he first came to town and in an emergency reports were sent back the same day. With the arrival of Doctor Anderson, x-ray coverage was provided not only for the hospitals in Saginaw but as far as Mount Pleasant and Alma. He continued on this schedule until 1947, when he obtained his first associate and now there are seven radiologists in Saginaw alone.

Another illustrious Saginaw doctor is Archer A. Claytor, who was the eleventh of 13 children born of slave parents, but all of whom received a college education. Doctor Claytor was appointed by President Eisenhower in 1958 to the Board of Directors of the Virgin Islands Corporation, and in September 1959 was named the Outstanding Family Physician of the State of Michigan. He has always been a kindly and faithful family doctor.

The notes on these few men give an idea of the caliber of the physicians in this Society and it is best that these examples suffice, lest in naming too many individuals, I fail to name many more equally worthy of mention.

We might well dedicate the history of medicine in Saginaw to Dr. Henry J. Meyer who was President of the Society in 1902 and is still walking ramrod straight, riding horseback and attending medical meetings at the age of ninety.

This story of success is somewhat dimmed by the knowledge that we have not given a President to the State Society since 1890. Perhaps, this can be remedied in the near future.

Adenoma of the Anal Gland In the External Anal Sphincter

Robert Bucklin, M.D.
Saginaw, Michigan

EXTENSIVE studies on surgical and autopsy specimens, fetuses, and newborn infants by several investigators[3,5] have demonstrated the presence of anal ducts in most humans. This structure was alluded to as early as 1871 by Gay. In the more recent studies, Tucker and Hellwig reported on the histopathology of these ducts in specimens removed for anal cryptitis and hemorrhoids. They observed minimal inflammation of the crypts but considerable inflammatory change about the anal ducts was almost uniformly present. Studying the anorectal regions in cats, dogs, guinea pigs and rabbits, they found these ducts to be more completely developed in the rabbit. No demonstrable function was noted in man and their significance in animals is not definitely known.

In man, the anal duct orifices are found within the anal crypts. They are essentially tubular and straight or spiral and usually have one to six branching tubules which rarely have an acinar structure. The ducts usually extend caudally through the muscular coat of the bowel and end blindly, although there is variation in both direction and depth. They frequently extend into the internal anal sphincter but seldom through it. The lining cells near the orifices form stratified squamous epithelium which gradually emerge with transitional epithelium, while near the blind end of the tubules and in the branches, columnar epithelial cells in two or three layers are commonly found. Fewer of these ducts are found anteriorly as most of them lie posteriorly. In no human case could true glandular tissue be seen. Kratzer was able to demonstrate mucus secretion in only a few cases.[5]

The role of these ducts in anal cryptitis and fistula was mentioned by several writers[5] but has not generally been appreciated despite strongly suggestive evidence.[5] In the past thirty years, numerous articles have appeared in the literature describing neoplasms of the anorectal region that are unique either in cell type or site of origin. Such titles as "Carcinoma of the Rectum Arising in Fistula in Ano," "Mucoepidermoid Carcinoma of the Anal Canal and Its Relation to the Anal Ducts,"[4] "Squamous Cell Carcinoma of the Rectum," "Pseudoinflammatory Colloid Carcinoma of the Rectum," and "Adenocarcinoma of the Ischiorectal Fossa" have frequently appeared in the literature and generally been viewed as separate entities. Cognizance of the work by Tucker and Hellwig prompted several writers,[1,2,5] notably Kay[4] and Zimberg,[7] to postulate that these neoplasms could originate from a common site, viz., the anal ducts. Many case reports to support this common origin have appeared in the literature.[1,2,5,6,7] The fact that the anal ducts contain three types of epithelial cells, squamous, transitional and columnar, could easily explain the origin of many squamous cells and adenocarcinomas of the anus. In addition, many neoplasms in their evolution may cause fistulae by extension and necrosis. To be conclusive, such lesions should be small, submucosal and subdermal and more or less located posteriorly and not involving the skin and mucosa at the anorectum. A small adenoma arising from the anal ducts in the external anal sphincter was recently seen here and a review of the literature failed to uncover any previous report. Although many histologic features suggested malignancy it is believed to be benign.

Case Report

JHW, a four-year-old white boy, was admitted with a two-year history of pain on defecation and sitting down. This, in turn, had led to poor toilet training and the cycle of pain, constipation, and more pain on defecation was quite a problem and had compelled the mother to seek psychiatric guidance. No fever, chills or discharge were ever noted. The mother had myasthenia gravis during pregnancy, and the boy was the product of a full-term gestation period with a spontaneous normal vaginal delivery. His past history included radiation therapy to the thymus, a pyloromyotomy for congenital hypertrophic stenosis, and a penile meatotomy. Two years ago he was thought to be hypothyroid and had since been taking 60 mg. of thyroid extract daily.

Examination on this admission revealed essentially negative findings except for a small tumor directly posterior and a little to the left of the midline at the anus. There were a

From the Department of Pathology, St. Mary's Hospital, Saginaw, Michigan.

few infected anal crypts posteriorly, and probing with a malleable wire failed to reveal any connection with the tumor. His temperature, hemoglobin, white blood cell count, urinalysis, barium enema and x-rays of the lumbosacral spine were all normal. At operation, through a posterior perianal skin incision, the mass was found to be submucosal and well

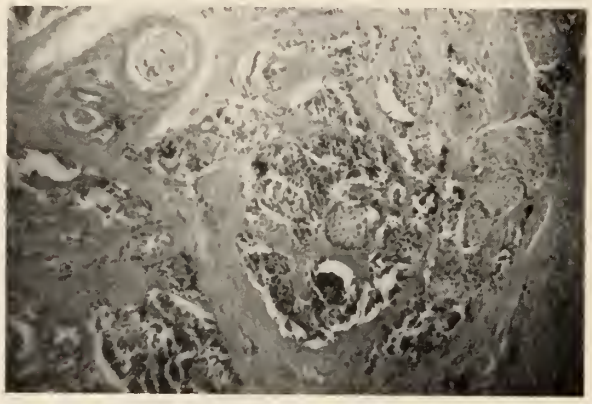


Fig. 1. Ducts and glands within external anal sphincter (100).

defined. It was dissected free from the external and sphincter in which it was embedded. The clinical impression was that of a neurofibroma or glomus tumor.

Pathology: #S-32295-58, gross. The specimen was a hard, gray piece of fibrous tissue measuring 1.5 x 0.8 cm. and without a true capsule. Cut sections showed a firm, gray fibrous stroma with streaks of yellow.

Microscopic Findings (Figs. 1 and 2): The nodule was composed of a fibrous stroma, in which there were small nests and clusters of round cells which had distinct association with nerve fibers. The cells appeared to surround the nerve bundles but were not considered to be a portion of them. They occurred in clusters of varying numbers up to approximately 50. There were a few epithelial lined submucosal glands in the lesion. Some muscle fibers were also present in the borders. A few vascular channels were present, but they were not unusually prominent. The lesion extended very close to the line of surgical excision. A mucicarmine stain showed no mucin in the tumor cells. It did show that mucin was secreted by some cells of an anal gland. The reticulin Laidlaw stain showed the tumor cell groups to be outlined by reticulin and there were no fibers between the individual cells. The Masson trichrome stain showed that the cell cytoplasm was very slightly acidophilic and very finely granular. These stains enable one to exclude carcinoma and carcinoid tumor.

Since the tumor was not in the skin, one can exclude an origin from the sweat glands. Morphologically, it bore some resemblance to sweat gland adenoma but its situation seemed to exclude an origin from sweat gland. On the other hand, the presence of mucus-secreting anal glands in the inner muscular coat of the anal canal points to an origin from the anal or intermuscular glands. There were one or two normal tubules in the section lined by a single layer of cuboidal cells.

It is believed that this is an adenoma of the anal gland vestiges and despite its resemblance to a carcinoma, it is not believed to be malignant, particularly since it has been present for probably two years in a four-year-old child. Re-examination of the child five years after operation reveals no palpable lesion or clinical evidence of recurrence. His bowel habits are normal, and there is now a happy domestic atmosphere.

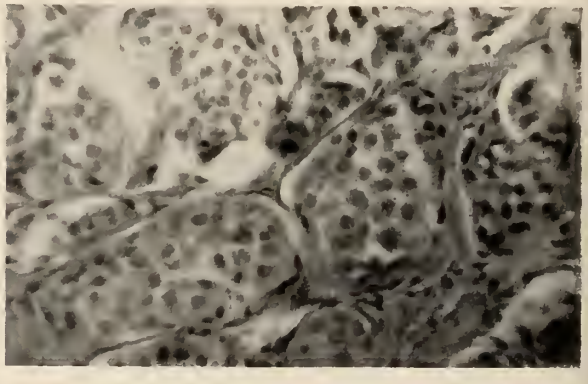


Fig. 2. Detail of gland structure (430).

Summary

The history of anal ducts in man is briefly reviewed. Their role in anal cryptitis, fistula and primary site of anorectal carcinomas has been reiterated. A small, painful, benign adenoma arising from the anal glands and embedded in the external anal sphincter in a four-year-old boy is reported. The child had pain on defecation and sitting down for two years. A review of the literature failed to uncover any previous report of this entity.

Acknowledgment

I wish to thank Dr. Arthur Purdy Stout for his helpful comments and generous assistance with the different stains. The operation was performed by Dr. Martin C. Sharp.

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A New Administrative Pattern In a Rehabilitation Program

V. K. Volk, M.D., Dr.P.H.
Saginaw, Michigan

THE CHRONIC Disease Service of Saginaw County Hospital was established in 1958 for the purpose of meeting the needs of chronic disease patients of Saginaw County. Of 103 beds made available, 16 were set aside for evaluation of patients' treatment needs prior to assigning the patients to one of two services: Rehabilitation for patients who have rehabilitation potential (53 beds), or Intensive Medical Care Service for patients in need of this service but who do not offer promise of rehabilitation (34 beds).

Since the inception of this service in 1958 to January 1, 1963, 522 patients have been admitted. Of this number, 98 per cent were welfare cases, and 55 per cent were 70 years of age or older. Of all admissions, 63 per cent were bedfast, 21 per cent semi-ambulatory, with only 16 per cent ambulatory. Fifty per cent of the patients were transferred from general hospitals and 10 per cent from nursing homes. Forty per cent of the patients came directly from their own homes.

Medical services to the patients are provided either by family physicians or two full-time physicians employed by Saginaw County Hospital. Regretfully, most of the patients are cared for by the hospital staff instead of being treated by their own family physicians, who are too preoccupied to take care of geriatric patients.

Consultants are available in every specialty, and a physiatrist from the University of Michigan visits the County Hospital Rehabilitation Center on a weekly basis to review the patients' progress every few weeks at the conference. These medical conferences are held jointly with members of the rehabilitation team composed of a physical therapist, an occupational therapist, a social worker, public health nurses, a rehabilitation counselor and others.

The goal of the rehabilitation program is to return the patients, insofar as this is possible, to normal and independent living. When this is not possible, the patient is trained by the rehabilitation team to make the most of his abilities. While the patient is at the hospital, the family is contacted (many times, if necessary) and motivated toward willingly accepting the patient upon his discharge and to help him otherwise to maintain the benefits attained in the hospital. Also while the patient is still in the hospital the home is prepared to insure safety and comfort to the patient on his return. Changes, such as building a ramp or providing railings on walls in hazardous locations, widening the door in the bathroom, et cetera, are all made prior to the patient's return home. When the patient is home, he is visited regularly by public health nurses and his family physician. When medical necessity requires, he is returned to the County Hospital Rehabilitation Center for a check-up and consultation.

Results

The intensive rehabilitation program in general yielded very generous dividends. Of the patients discharged, 89 per cent improved. We consider improvement in the patient's condition to exist when his clinical status is changed prior to discharge. In other words, when a patient on admission is bedfast and on discharge is semi-ambulatory, we consider the patient improved.

A most interesting fact to us was that 61 per cent of the patients discharged were returned home and only 6 per cent were sent to a general hospital. Thirty-three per cent were transferred to nursing homes or medical care facilities to continue receiving necessary nursing care. The average length of hospitalization of discharged patients was 155 days.

Of the 127 patients who expired, 40 per cent died during their first 30 days of hospitalization.

Our Disappointments

As satisfactory as our results were, there is room for improvement, since some patients regressed after discharge, and some even had to be rehospitalized at Saginaw County Hospital Rehabilitation Center one or more times. This can be seen from Table I.

The study of Table I shows that 25 per cent of all patients were readmitted in a stage of regression with the same admission diagnosis as at the time of previous discharge. This Table does not include readmission of

TABLE I. REGRESSED PATIENTS REQUIRING MULTIPLE ADMISSIONS
SAGINAW COUNTY HOSPITAL—CHRONIC DISEASE SERVICE
9-3-58 to 12-31-62

After First Hospitalization Patient Was Discharged To	First Admission		First Readmission		Second Readmission		Third Readmission		Fourth Readmission	
	No. of Patients	Days in Hospital	No. of Patients	Days in Hospital	No. of Patients	Days in Hospital	No. of Patients	Days in Hospital	No. of Patients	Days in Hospital
Home	68	10,286	49	5,198	10	849	3	231	1	86
Nursing home or infirmary hospital	16	4,079	18	2,630	1	128	1	105	0	0
Expired	0	0	10	968	2	25	0	0	1	163
Still hospitalized	0	0	7	1,111	1	322	0	0	0	0
Totals	84	14,365	84	9,907	14	1,324	4	336	2	249

Total number of patients discharged 330

Total number of patients requiring multiple admission 84

Total number of multiple admissions 104

Age Group of Discharged Patients
Under 50 14%
51-60 14%
61-70 17%
71-Over 55%

patients for conditions other than at the time of first admission.

In analyzing Table I, there are a few facts worthy of note. Almost 25 per cent of the patients had to be returned to the Rehabilitation Center to regain lost ground. Some of them had to be readmitted twice, or even three times. The fact that a large group of patients required repeated hospitalization prompted us to delve deeper into the problem and ascertain the reasons responsible for this situation.

We concluded that the patients should have received a more aggressive rehabilitation program than a home care program can usually offer. We found that, despite our efforts, many families lacked motivation themselves to stimulate the patient's desire to carry out his rehabilitation program, which requires fortitude, persistency, and "do it yourself" efforts by the patient. Very frequently in home situations family members are breadwinners, and they cannot give enough time to assist the patient in the treatment program and thus stimulate him in the rehabilitation efforts.

We found that the family, regardless of the affection which they have for the patient, cannot acquire the skill and competence which are needed in assisting the patient in a rehabilitation program. Visits made by the family to the Rehabilitation Center or by the Rehabilitation Nurse to the family are not enough, especially when the patient himself, more often than not, is not ready physically or psychologically to be a homebound patient.

In our own experience, the shortage of beds, a long waiting list and the availability of the home care program resulted in a discharge of some patients who apparently were not ready to pursue further treatment at home and thus maintain the benefits achieved at the hospital.

The situation does not suggest that encouragement should not be given to the patient to go home after a period of hospitalization, but it does indicate that both the family and patient must be better prepared for the patient's return home in order for him to maintain the full rehabilitation benefits of hospitalization.

In our opinion, the patient, after leaving the hospital, gives up too much and too soon the hospital routine in return for home care.

In the hospital, the rehabilitation program is a way of life. It is a religion by which the patient lives, and everyone at the hospital sees to it that this way of life and religion are practiced by the patient. This is not often the case when the patient returns home, because the dynamic concept of rehabilitation cannot be practiced at home.

To summarize, it is our conclusion that the reason for some of the failures by the patients to maintain their hospital benefits at home are:

1. The patient neither psychologically nor physically can practice rehabilitation treatment at home even under the best home care supervision.

2. The families are not prepared treatment-wise or psychologically to assist the patient.

It is our judgment that there must be a gradual change-over from hospital routine to a home situation. Our present need is to narrow down the existing gap between hospital service and home care treatment. In other words, it looks as if the problem could be solved in the majority of cases by adding one more step to tie up the hospital and home care programs by developing a Day Care Rehabilitation Program. In brief, this plan is as follows:

We propose to provide the discharged patients with treatment both at the hospital and at home. During the day, the patient would be brought to the hospital

and offered the necessary rehabilitation service in physical therapy, occupational therapy, sheltered workshop and all other special rehabilitation services, including medical supervision, while remaining on an out-patient status. Late in the afternoon or in the evening, the patient will be returned home on a special orthopedic bus. This service would be much the same as a school bus transporting children from home to school except that the bus will have a hydraulic platform so that the patients in wheelchairs can ride in comfort in their own wheelchairs.

While on the day-care program, the patient would be given an opportunity to rest, to have a well-balanced and nourishing meal, and to do all other things the patient wished to do in a leisurely manner. After receiving this hospital-oriented care, the patient would be returned home in the evening. This type of treatment would be offered to the patient on a medically prescribed basis. As the patient continues in the program, his medical and physical needs will diminish and his visits will become less frequent. Our goal is to make the patient as time goes on more home-oriented than hospital-oriented and it is our hope that the patient will eventually develop stronger motivation for home care treatment.

We believe that the Saginaw County Day-Care Program will make it possible to treat 30 or 40 patients a day. As the program progresses, we hope to achieve the main objectives of the program: namely, to maintain treatment benefits, and to reduce the number of regressed patients and the number of patients requiring rehospitalization.

As important as this goal is, we look beyond it and question whether or not this new administrative pattern can lead to another and even more important achievement. We all know we can never build enough hospitals to take care of all long-term patients. When the Day-Care Program is in operation, we plan to shorten the present length of hospital stay by at least 25 per cent. On the Day-Care Program the patients will receive essentially the same treatment and rehabilitation benefits as they receive in a total hospital program. Surely, it would be worthwhile to try to find out whether the Day-Care Program can cut down on the length of hospitalization of long-term patients without sacrificing the patients' needs.

In conclusion, our proposal for a day-care rehabilitation program may lead to:

1. A substantial reduction in the number of regressions and rehospitalizations,

2. Better adjustment by patients to a home situation through an intermediate hospital-home care approach,

3. Substantial reduction in the length of hospitalization of long term patients needing rehabilitation,

4. Increased utilization of the chronic disease hospitals as a result of shorter hospital stays,

5. Closer supervision of the patients by the family doctor.

This pilot program was inaugurated on June 1, 1963, at Saginaw County Hospital, with the financial assistance of the Public Health Service and cooperation of the Michigan Department of Health. We believe that time will prove that this new administrative pattern to be a practical approach to the complex and extremely costly problem of medical care for the aged.

Medical Maxims

Pyuria in the diabetic should always be thoroughly investigated.

Bleeding from the anterior urethra may be the first or one of the early signs of malignant hypertension.

Renal carcinoma should always be considered as a possible cause in fevers of unknown origin.

Surgical intervention for ruptured intervertebral disc is urgent only for uncontrollable pain or severely impaired nerve function.

Suspect fracture of the cervical spine in all head injuries.

From "711 Medical Maxims, II" by WILLIAM S. REVENO, M.D.; Publisher, Charles C Thomas, Springfield, Illinois

Routine Choledochotomy With Cholecystectomy

John Warren Manning, III, M.D.
Saginaw, Michigan

DURING the past ten to fifteen years, there has been a running discussion in the surgical journals concerning the ideal and safest treatment for both acute cholecystitis and chronic cholecystitis. There have been many advocates of cholecystectomy with and without choledochotomy for acute cholecystitis.

Dr. Frank Glenn[1] has reviewed his excellent results in 697 patients on whom he has performed cholecystectomies for acute cholecystitis with an overall mortality rate of approximately 2.7 per cent and a very low postoperative morbidity. In rebuttal, Dr. Robert Buxton and Dr. Frederick Coller[2] have advocated a more conservative approach with cholecystostomy recommended as the operation of choice in the acute phase and later cholecystectomy. Their mortality was in the range of 1 or 2 per cent and they state that cholecystectomy mortality rate may be as high as 10 per cent.

There have been many others who have encouraged cholecystectomy in all patients with cholelithiasis and indicated that they considered common duct exploration is both a safe procedure and chronic phase. Dr. Bentley P. Colcock[3] has reviewed 2,460 operations on the biliary tree performed at the Lahey Clinic and has shown that approximately one-third of the patients whose common bile ducts were explored, had stones in them. Common bile ducts of about one-third of this group of patients were explored. He also found that the morbidity was increased by only one or two extra hospital days when the bile ducts were explored, and the mortality rate was almost identical. Cholecystectomy alone had a 0.9 per cent mortality rate, while cholecystectomy and choledochotomy had a 1.1 per cent mortality rate.

Because of these varying opinions and different surgical approaches, it was decided to perform routinely a choledochotomy and cholecystectomy on all patients, if surgically or medically possible. It would thus let us compare the following factors:

1. We could determine the overall mortality and morbidity rate in a community-type hospital as against that found in the literature from the large university centers for this operation.

2. We would see if by doing choledochotomy on 100 per cent of all cholecystectomy, we could determine whether we obtained a much higher incidence of choledocholithiasis.

3. We could determine whether routine choledochotomy increases the morbidity and mortality.

4. We could determine whether routine choledochotomy increases or actually decreases the incidence of common duct stenosis.

In this blind series which we have conducted, all patients with surgical biliary tract disease were subjected to cholecystectomy and choledochotomy with the insertion of a T-tube. The only exceptions to the procedure were five patients who were considered to be aged, septic in extremis or had such severe medical or surgical illnesses that they could not tolerate a general anesthesia.

This group had simple cholecystostomy and this was performed under 1 per cent local novocaine or xylocaine anesthesia. Two of these patients improved enough to have cholecystectomy and choledochotomy later, and they were found to have common duct stones and have done well.

Each patient in this series was studied as to age, sex, operation performed, and whether stones were present in the gall bladder or the common bile duct. Also, of course, we followed the question of morbidity, type of complication, and mortality rate.

The age of our patients ranged from 16 years to 85 years and, of course, the older age group had vascular diseases as their most common concomitant illness, with angina pectoris and coronary artery disease being frequently present.

We have thus performed 150 cholecystectomies and choledochotomies in our group which have included acute, subacute and chronic cholecystitis. In this series of patients, we have had an overall mortality rate of 1.5 per cent. This compares with the mortality ranging from an operative mortality rate of 8 per cent in acute obstructive cholecystitis with only cholecystectomy performed as reported by Dr. David B. Hinshaw and Dr. Richard Carter,[4] against the mortality rate of about 1.1 per cent as reported by Dr. Bentley P.

Colcock and Dr. James E. McManus[5] in their series of 1,356 cases of cholecystitis with cholelithiasis.

Our incidence of common stones was found to be 22 per cent, which we believe is significantly higher than the usually reported 10 to 15 per cent choledocholithiasis found in the series in which only approximately one-third of the total cholecystectomy patients have their common duct explorations performed in a selective manner.

We have not included 12 cases which contained mud or inspissated bile in our studies as these would, of course, raise the incidence another 8 per cent. The complications in this series, I think, are worth reviewing. We have not as yet been able to recognize stenosis or have we had inadvertent ligation of the common bile duct. We hope this is partially due to the good visualization which develops at the time of choledochotomy in contradistinction to the more or less blind ligation of the cystic duct in cholecystectomy alone. Dr. Richard B. Cattell[6] has shown in a series of 1,000 operations for repair of the common bile duct that 90 per cent resulted from faulty technique at the time of cholecystectomy. We thus believe that gentleness in handling the common duct at the time it is opened, as well as careful closure around the T-tube with good visualization, has prevented this serious complication. In addition to this technique, the closure of the common duct is performed with an absorbable suture, 30 chromic instead of silk, as we have seen previous to this series, calcareous deposits develop around silk in the common duct and we believe that absorbable sutures will dissolve before this complication occurs.

There has occurred one case of bile peritonitis which we think was caused by postoperative pancreatitis with spasm and edema of the sphincter of Oddi, causing back pressure and leakage. This may have been either initiated or aggravated by poor drainage from the T-tube brought on by the collection bag being immediately strapped to the anterior aspect of the right thigh after surgery and the resultant elevation of the biliary pressure because of poor drainage. Thus, the pressure being high resulted in either leakage around the T-tube or blowing the cholecystic stump.

Our other complications fall into the usual major groups: (1) wound abscesses, (2) herniae of the drain and T-tube site, (3) atelectasis, and (4) vascular disease (phlebitis and coronary occlusion).

We have had four wound abscesses but these have not delayed the patient's discharge by more than about two days, our usual discharge day being the ninth surgical day. On a several months to several years follow-up, two herniae have developed either at or just medial to the site of the T-tube or soft drain.

Atelectasis has occurred on three occasions, but has not been of a significant severity to require bronchoscopy. Early ambulation has been the rule; out of bed on the first or second day.

Major Complications

Bile Peritonitis	1*
Wound Abscesses	4
Atelectasis	3
Post-operative Wound Herniae	2
Thrombophlebitis—Superficial	1
Deep	1
Coronary Occlusion	1*

*Expired

The vascular diseases we have observed have been three cases of superficial phlebitis and one case of deep phlebitis. The latter required anticoagulant therapy.

In addition, there was one coronary occlusion in a 72-year-old patient which was massive and caused the other fatality in this series.

Summary

In reviewing our 150 patients in which we have performed routine choledochotomy at the time of cholecystectomy, we believe choledochotomy has not appreciably increased the morbidity or the mortality rate in our community-type hospital a significant degree.

When we compare the incidence of common duct stones which we have found (22 per cent), as against those found by Dr. Alex E. Pearce[7] (about 15 per cent) and others who perform approximately one-third choledochotomies for cholecystectomies performed, we have found a significantly higher incidence. We believe and it appears that possibly selective or surgical judgment choledochotomies may thus be missing a large number of stones.

Hence, routine choledochotomy in our hands may have been a worthwhile procedure not only because of the increased opportunity for avoiding a second operation for common duct stones, but also the greater visibility that results from cleaning the common duct which is necessary in doing a choledochotomy. This also prevents inadvertent injury to the common duct and a lessened incidence of ligation or postoperative strictures developing. So far, we have detected no strictures, but shall continue to follow and report on this problem.

(Bibliography is on page 766)

Torticollis Can Be a Diagnostic Problem

John O. Goodsell, M.D.
Paul R. Noble, M.D.
Saginaw, Michigan

TORTICOLLIS in children is not rare. The major division in kind is between congenital and acquired. The commonest variety of the former is that due to asymmetrical contracture of a sternocleidomastoid muscle (incidentally of uncertain cause), and this can be relieved by relatively simple physical methods or operation. Because it is correctible,[1] it is important to distinguish early between this and other congenital types such as skull deformities, Sprengel's deformity (congenital elevation of one scapula), Klippel-Feil syndrome, and hemivertebra (congenital scoliosis),[2] all of which in varying degree are more resistant to correction.

Acquired torticollis may result from trauma, acute infections (e.g., pharyngitis), meningitis, poliomyelitis, tuberculous adenitis, cerebellar tumors, visual disturbances, emotional disturbances, etc. Since wry neck in these children is secondary to other disease, treatment of the cause and mechanical replacement of dislocation, if present, should correct the deformity.

As with all disease, success in treatment depends on accurate diagnosis. The case to be reported demonstrates that diagnosis may be difficult. The parenthetical commentary and references are partially retrospective.

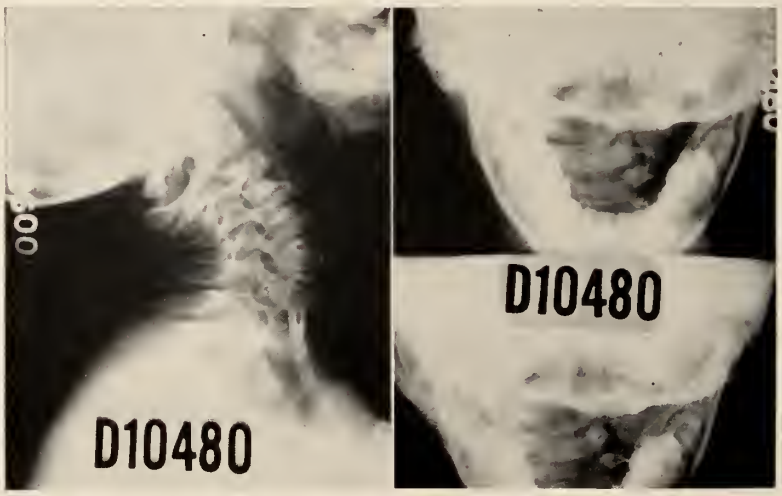


Fig. 1. Lateral cervical spine and two attempts at anteroposterior odontoid.

Case Report

T.L., a boy, was born at Saginaw General Hospital on January 30, 1957, by "normal delivery." Neo-natal examination revealed no abnormality of consequence.

On August 16, 1961, at the age of four and one-half years, he was struck by an automobile and sustained a compound fracture of the left tibia with fracture of the fibula. According to witnesses, he was not thrown violently, but the leg was injured when a wheel ran over it. The same day, debridement, reduction, and application of a long leg cast were done. A house officer's note indicated the presence of "a hard swelling in the left postparietal area." Convalescence, insofar as the leg was concerned, was uncomplicated; the cast was removed October 25, and he was walking well on November 6.

On December 4, 1961, he was returned by his mother to the Saginaw General clinic (Michigan Crippled Children Commission, where he was seen on all prior as well as subsequent occasions by J.O.G.) because of a twisted neck which had made its appearance on about November 11 at the conclusion of an attack of "measles." No physician had been in attendance for the "measles," but his mother made

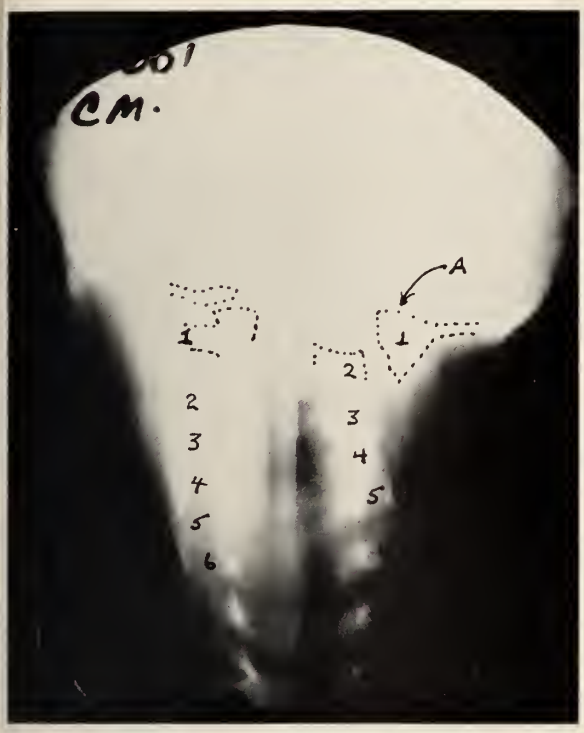


Fig. 2. Planigram, one of many body section films, outlined for clarity.

Because of failure to improve, the boy was hospitalized from December 18 to December 23, 1961, and was treated in head halter traction. Additional studies including C.B.C., urinalysis, erythrocyte, sedimentation rate, chest x-ray, examination, and E.N.T. consultation turned up no diagnostic clues. On December 29, he appeared vigorously healthy as throughout the entire course, still had torticollis as throughout the entire course, but had complained a little of headache according to his mother. During one more hospitalization from January 2 to January 8, 1962, spinal fluid examination gave normal findings, and neurosurgical evaluation added nothing except to reassure about absence of cerebellar tumor. One house officer believed that during sleep the boy's head assumed all positions normally.

Now, the possibility of conversion reaction was considered, and Prochlorperazine was administered for a month without significant effect. Pain had ceased before that to be part of the picture. Psychiatric evaluation was sought and finally obtained (Saginaw Valley Child Guidance Clinic) on October 3, 1962. No overt problems were uncovered.

Repeated cervical spine x-rays on September 10, 1962, were no different from prior ones, which is to say the upper cervical spine could not be adequately evaluated, although lateral films made it clear that there was not significant—probably no—odontoid hypoplasia. On September 28 one of us (P.R.N.) performed planigram studies and demonstrated clearly abnormal relationship of the occiput, atlas, and axis (Fig. 2). Although the boy had been entirely asymptomatic for months except for torticollis, a Forrester collar was then applied because of fear that this might be an unstable situation. Due to aversion to the collar, it was not worn very faithfully and finally was discontinued because it seemed unnecessary.



Fig. 3. Resting, "neutral" attitude in April, 1963.

that diagnosis for him as well as for siblings similarly afflicted. His head then was rotated about 30 degrees to the right, and passive efforts to straighten it caused pain. Temperature was normal. Chest x-ray examination revealed no abnormalities. Cervical spine x-rays were difficult to interpret due to cervical scoliosis, and further due to inability to obtain a satisfactory open-mouth view of atlas-axis relationship (Fig. 1). This latter problem was never solved on subsequent attempts, evidently not an unknown problem. ("Difficulty in interpreting cervical spine films commonly arises in relationship to the first and second cervical vertebrae.")[3] A plaster cervical collar was applied.

The final reassurance about the stability of the spine was obtained by cineradiography of complete flexion and extension of the neck on March 13, 1963. This demonstrated no hypermobility, perhaps some restriction of motion.

For the past year (March 1962 to April 1963), this boy has been symptom-free except for painless torticollis, which is less pronounced than originally and is no functional handicap (Fig. 3). The cause of this torticollis remains not

quite completely determined. The history almost eliminates a solely congenital origin and further makes trauma appear an unlikely culprit because of chronological relationships. The "measles" story hints at spontaneous, unilateral dislocation of C1-C2 associated with pharyngitis.[4] The planigram clearly shows asymmetry of the lateral masses of C1, and appears to show fusion of one lateral mass to the occiput (Fig. 2, A). Such fusion would seem most likely to be congenital, which conclusion completes the speculative cycle back to an otherwise untenable diagnosis. In any event, the deformity is now incorrectible, and it may only be wondered when and if it was at a correctible stage.

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Medical Aspects of Water Sports

The Fourth National Conference on Medical Aspects of Sports, sponsored by AMA, offered a panel on "Medical Aspects of Water Sports."

Charles G. Hutter, Jr., M.D., of Hollywood, California, panel chairman, said:

"As the result of inventions and applications of mechanical devices, new uses of our geographic surroundings have developed. These new challenges or sports offer great thrills, most often of an individual nature, of man against the elements.

"Thus water skiing, underwater exploration, underwater fishing and conquering the waves on a surfboard have become popular with many of our robust young men. The dangers and physical hazards associated with these new challenges do not become apparent until such complications are reported by physicians," Dr. Hutter reported.

"Only after the compilation of these complications can medical recommendations be made to prevent them. To make such medical recommendations effective, the public must be made aware of them and the precautions necessary to prevent them," Dr. Hutter emphasized. "This should be done by disseminating such information widely throughout the population rather than an attempt at legislation to prevent them."

L. M. Morrisset, M.D., of El Cajon, California, who discussed "Sport Scuba Diving and the Physician," said that "the phenomenon of being an unencumbered underwater swimmer has attracted thousands of people to the sport of Scuba diving. This sport has many hazards attached to it which are not readily apparent unless the participant is properly enlightened to them and trained in the use of the equipment.

"The physician can assist his patients that are planning to do Scuba diving or are diving to be informed of all the problems associated with this sport," Dr. Morrisset pointed out. "Most of the physicians that have become familiar with this subject are avid divers themselves. It is to be emphasized that the most dangerous thing the diver will encounter in the water is the diver himself."

Ernest M. Burgess, M.D. of Seattle, in covering "Water Ski Injuries," said that "participation in the sport of water skiing continues to grow impressively both in the United States and abroad. This absorbing sport draws enthusiasts from all age groups and all walks of life."

Dr. Burgess indicated that "as equipment and technics are becoming better known and standardized, the physical hazards involved are better understood, as are the physical requirements for safe participation." He also pointed out in detail the technics, safety precautions and types of injuries seen in this sport and suggested preventative and safety measures and means for their evaluation.

A Challenge to Medicine

Arno W. Weiss, M.D.
Saginaw, Michigan

IT IS with deepening concern that many of you have at some time in the past expressed yourselves with regard to medical manpower in this country in the years to come, both as to quantity and as to quality. It has become obvious to you that there is a need for more physicians in this state, and that the need will become greater in the future. It is also obvious to you that there is a need for this nation as well as this state to fulfill this need by the training of more of its own physicians. In 1959, there were 119 non-federal physicians per 100,000 population engaged in active practice in the United States. This ratio has remained constant in recent years only by importing large numbers of foreign-trained physicians. In 1959, there were 8,482 physicians in practice in the State of Michigan: 9 per cent of this number were trained in foreign medical schools. During the same year, there were 8,400 foreign trained interns and residents in our U. S. hospitals. This represented 24 per cent of the total intern resident staff of this country. Physicians are entering this state at a rate which fluctuates between 100 and 150 per year in spite of the fact that 57 per cent of the physicians trained in Michigan remain here while the national average is 46 per cent. By 1975, 330,000 physicians will be required in order to maintain the ratio of 119 physicians per 100,000 people. To reach this number will require an additional 3,600 graduates in medicine per year, and this is an increase of 50 per cent above our present output.

It will be 1970 before any of this output increase will be realized, and if it is not, then let me ask you—how will you work another six or seven hours a day? What quality of medical care do you expect you will render? Under these circumstances, how long do you expect you will live?

Dean Hubbard of the University of Michigan Medical School has said that the freshman medical classes at the University of Michigan with an enrollment in the neighborhood of 200 have reached the maximum size that allows for peak efficiency in medical education. As you know, Dean Scott's allotment for the College of Medicine of Wayne State University has been cut by the state legislature, with the result that this not only eliminates any possibility of expanding the size of the Wayne State medical classes at the present time but has required the discharge of faculty members. It is obvious that there is a need for an increase in financial assistance at this institution where the situation has reached a critical point. Doctor Hubbard says that there is also a need for additional funds at the University of Michigan Medical School.

Only a few years ago, President Hannah said that he did not desire a medical school at Michigan State University until the expanded facilities at the University of Michigan and Wayne State University could not meet the medical needs of the state. This state is designated as one of 11 not producing its quota of physicians. There were many plans at Michigan State University which had priority over a medical school. Today, President Hannah will tell you, "We do not feel at the present time that we can afford to proceed with a medical school, but we also do not feel that we can afford not to." From the preceding figures regarding the need for an increase in the number of physicians, it is easy to understand why this statement was made. From the preceding facts, it is also easy to understand why you should concern yourselves with the allocations of our state legislators in behalf of higher education. There is a necessity for the current practicing physicians to assume their obligation by attracting high school students to the field of medicine. Some of you

The Author
ARNO W. WEISS, M.D.



Address given before the Saginaw County Medical Society in January, 1962.

have already made your awareness of this problem known by the formation of a future doctors club, and by yearly receptions which you hold to honor the outstanding high school seniors. You are to be commended for your work in this area. There is also an urgent need for the Michigan State Medical Society to emphasize to the state legislature that the funds set aside for the colleges and universities of this state are wholly inadequate to maintain a high level of medical education. It is interesting by way of comparison to note that the University of Illinois annually receives an allotment from its state legislature which is in excess of the combined allotments to the University of Michigan, and Michigan State University.

During the academic year 1960-61, the University of Illinois received an allotment of 60 million dollars to educate 29,000 students, while during the same year the combined allotments to the University of Michigan and to Michigan State University totalled 58 million dollars to educate 53,000 students. While bigger bridges are being built over small streams in remote areas of this state, less doctors can be educated by the College of Medicine of Wayne State University, and so you will agree that somewhere a sense of values has been lost. What is more, if we do not bother to tell some one about it, then you will have to agree that there is something wrong with our sense of values. And so the struggle for survival by our institutions of higher learning goes on as they carry out their mission to preserve, to convey, and to discover new knowledge.

While the State of Illinois already has five medical schools, plans are in the making for a sixth one at the two-year level. You have read in the AMA News in November that a number of other states are now in the process of building medical schools at the two and four-year level.

You will be interested, I am sure, to hear a brief statement regarding the Institute of Biology and Medicine at Michigan State University. It is proposed that the facilities for this Institute be constructed from gifts and grants from foundations and federal agencies. The Institute will be a two-year medical school with a planned enrollment of about 50 students in each class. With an average loss of about 20 per cent, this school eventually will produce about 40 students annually for transfer to other medical schools for the clinical years. Even then, the State of Michigan will fall far short of producing its quota of physicians. The Big Ten schools have an average annual vacancy in each class of 20 at the clinical level so that no difficulty is anticipated in finding positions for the graduates of this program. It should be mentioned that there are presently three two-year schools in operation. These have an excellent reputation and find no difficulty in placing students for clinical training.

According to the McNerney Report, published by Dr. Walter McNerney of the University of Michigan, this state will have to provide an additional 279 first year places in our medical schools by 1967. Wayne State University at full expansion numbering 200 will provide 75 of these, and MSU will provide another 50, leaving a total of 154 first year places still to be provided only five years from now.

The Institute will also prepare Ph.D.'s for teaching in medical schools and these students will pursue an almost identical course with the medical students. This will allow flexibility by attracting potential teachers into the fields of medicine and vice versa. An indication of the need for more teachers in medical schools is the fact that there exists outside of this state 851 vacant full-time medical school faculty positions with money available for these positions.

The Institute of Biology and Medicine at Michigan State University is well supported by the library which, for many years, has bought textbooks and subscribed to over 300 journals in all fields of human medicine, many of them complete to the original issues. The library has been used for graduate training, medical technology, nursing education and other health-related fields.

In order to begin the medical program at Michigan State University some ten faculty members will be added to the existing faculty in the basic medical science departments at the University. These departments have already made outstanding contributions to the field of human medicine. In the departments of Biochemistry, Pharmacology, Microbiology, Bacteriology, Botany and Physiology are faculty members who have distinguished themselves by their research and their achievements in the fields of kidney and liver function, endocrinology, radioactive tracer studies, thyroid function and medical mycology. Several Michigan State University faculty members in the basic sciences have taught previously at four medical schools in this country. The Michigan State University Institute of Biology and Medicine aims to take the comparative approach to the biological sciences. They are

convinced that this approach will produce more broadly trained physicians. There will, of course, have to be some clinical training in the two-year program at M.S.U. The Ingham County Medical Society has already pledged its support in regard to the availability of patients for the teaching of history taking and physical diagnosis.

In recent years, while the number of college graduates has increased, the number of applicants for each opening in the medical school freshman classes of this country has decreased from 3.5 in 1948 to 1.8 in 1960. One of the reasons for this decrease is the fact that during the past 15 years 1500 more vacancies have been created at the freshman level in the medical schools of this country. Another reason more obvious is the fact that medical scholarships available to qualified prospective medical students are conspicuous by their almost complete absence. Each year, Michigan State University attracts to its campus nearly 1000 of the sharpest high school seniors from nearly all the states to compete for 10 distinguished scholarships worth $1000 each. The alumni of Michigan State University annually provide $40,000 for this purpose as a part of their giving. I am sure that a similar situation must exist on the campuses of your colleges or universities. A few years ago among this group of 40 outstanding students at the various four-year levels, there were six premedical students. I am proud that some of you in this room made a contribution in behalf of these people and that others of you have made contributions to your alma maters. It is with much regret that I must tell you that some of these premedical students to whom I referred never reached medical school. While industry creates and establishes scholarships to attract worthy and needy students into their fields, what does medicine do in this regard? I am told that once a man gets into medical school, he is told there is a place he can borrow money to complete his training. Then we complain that the "good men" by-pass medicine to go into industry. It should be quite obvious that in the majority of instances, the embryonic physician has already proven his worth by the third year of his premedical study. The answer, then, is to follow the lead of industry by establishing scholarships in the field of medicine. By the same token, if we exert our efforts in behalf of higher education by alerting the legislators of this state to the fact that their present allocations to our colleges and universities have resulted in a critical situation, we will not have to complain so much that our better teachers are leaving our institutions of higher learning to go into industry.

If you would say that you worked your way through college—and let the other fellow do the same —then you will have to be reminded that if you attended a so-called state-supported institution, when you paid your tuition you paid only one-fifth or one-sixth of the cost of your didactic training. If you attended a private institution, you must be reminded that you acquired your education only through the generosity of others—industry, foundations, institutes —and if this were not true, the alumni of our institutions of higher learning would not be rallying to the cause of education as they are. In one of our eastern universities, the alumni gifts to their school total as high as 8 million dollars in a single year. Actually, the so-called state supported institutions in this state are in reality not being supported but are existing as best they can on a financial diet which is little short of starvation.

In your defense, as you contribute your share of the 2/3 of a billion dollars of free medical care which is given annually by the doctors of medicine of this country to the needy, I must say that you are among the best bargains this state ever produced or received. It is not my intent to be critical of you individually, but to point out that we are a society, and as such we must be critical and examine ourselves as any society must do. You already know this, and if you did not, after your many years of study you would not bother with postgraduate education. It is of interest to note that tonight before dinner we assembled as usual to enjoy the good fellowship of our colleagues and along with this a bit of spirits which probably cost us each no more than $1.20. If each member of the Michigan State Medical Society, once a year, would contribute this amount to a scholarship fund, the end result would be more than enough to cover the cost of educating five medical students for a year. Besides, we would then not have to complain that so many good young men are passing medicine by to go into industry.

In 1961, you have enjoyed medical leadership at its finest under the guidance of your President, Dr. Hugh Caumartin. To this you will certainly all agree. We have appreciated not only his efforts in our behalf but his warmth, his sensitivity and his sincerity. It is my hope that as you search for leadership in medicine at the state and national levels in the years to

come that you remain cognizant of this man, for we shall always be in need of his type at these levels. It should be of interest to all of us that he has conveyed to you in a recent Bulletin, a President's message in behalf of education. Your President is cognizant of the fact that we have no right to remain complacent in 1961 but must look ahead to 1975. If we were to begin a new medical school now, it would be 1971 before we could produce a family physician and 1975 before we could produce a specialist. Therefore, it is my sincere hope that you will instruct your President to convey to Dr. John Hannah and the Academic Senate of Michigan State University the appreciation and support of this Saginaw County Medical Society for their efforts in behalf of medicine. It is also my hope that you will instruct your delegates to the Michigan State Medical Society to make that body aware of the financial requirements of higher education in the State of Michigan, so that as a result of such instruction, the Michigan State Medical Society might assume its obligation to alert the legislature to the need for realistic appropriations for higher education. Bear in mind that we are products of education and not necessarily products of medicine. Also bear in mind that were it not for our colleges and universities, we would find ourselves far removed from this room tonight, digging an endless hole in the earth from which there would come neither spiritual nor intellectual reward.

From my good friend, Dr. Paul Miller, President of the University of West Virginia, comes this message: "As students we must learn to be sincere, to be sensitive, and after we receive our diplomas, we must continue to learn."

You have all said many times that you are proud to be a member of the Saginaw County Medical Society and that this is the best place in the world in which to practice medicine. If this is true, we should not simply come into this society and assume that this heritage is ours, then go our way without regard for our colleagues or our society. But we should make an effort to preserve and to make a contribution to this heritage by instructing our delegates to the Michigan State Medical Society to promote medical scholarships. Thereby we shall convey to the state level the best traditions of the Saginaw County Medical Society.

The football season has just passed, and with it we have enjoyed an exchange of punts and have taken our ribbings after a not-so-good Saturday. This is good, this is healthy because it signifies pride in one's college or university. This is as it should be. Tonight, however, we are not to argue which school is the better or which is to receive the most money. Such an argument would be as ridiculous as to argue who is better—the family physician or the specialist. In view of the problems which medicine faces today, such thinking belongs squarely upon the junk pile of medicine.

It may be inconceivable to you that in 1958 the American public spent 18 billion dollars on entertainment, over 9 billion on alcohol, over 6 billion on tobacco. While the total of these items was a good deal more than was spent on total medical care including health insurance, those same people were exercising their vocal cords, screaming for your very necks so that they might not only destroy the finest medicine in the world but also at the same time begin their destruction of the finest nation in the world. It is inconceivable that there are people in this state, as well as in the nation, who are doing everything they can do to stimulate an audience of receptive ears into thinking that medical care for the aged should become a function of Social Security, regardless of the size of the individual bank roll, while our legislature has already enacted the Kerr-Mills bill to do the job without reducing any to the role of a pauper. Yet a certain element seizes the Social Security role as a vote getter, regardless of cost and regardless of the fact that it would literally destroy the very fibre of this nation. This is in contrast to the fact that you long ago rendered your services without charge when necessary, not only to the aged but to all ages, not as a vote getter but rather in commitment to an ideal. I am reminded of the infamous character whose malignant thinking plunged this world into a war little over two decades ago. From his many warped cerebral deductions emerged this thought, "If you wish to acquire a purely socialistic state, get medicine first for this appeals to the masses. Then the rest will be easy." It is rather ironic that the British who suffered so much as a result of this warped thinking should fall into his very trap by instituting compulsory government medical care for themselves. While today the free nations of the world are busying themselves in an attempt to overcome the political blunders of World War II, the Britishers, with their bellies filled of it, are slowly but surely emerging from the hell holes of compulsory government medical care. In spite of the fact that they are among the highest taxed nations in the world, in spite of the fact that they have already paid for their free medical care with their taxes, these

same people are pinching their pennies to buy a freedom—private health insurance—the fastest growing industry in the whole British Empire. Politicians, please take note.

It is also inconceivable that the American public in 1958 would spend over 34 billions on entertainment, alcohol and tobacco and then quibble about spending less than 5 billions on education.

There are some who will tell you that the cost of higher education should be borne by those who receive it. To refute this argument, Doctor Hannah thus has to say, "Where do the greatest benefits flow from the education of a doctor: To the physician himself or to those whose pain and suffering he relieves?" This quotation is from the President of the only university in the world with a Dean of International Programs, sending its faculty to the far corners of the earth to teach the underprivileged of the world a more democratic way of life. These people in South America, Okinawa, South Vietnam and Africa who have a hunger for knowledge represent an obstacle in the path of the brain-wash of the communist. This interpretation is my own and not necessarily that of the university's.

Many times you have written your check to the United Fund only to hear the doorbell ring and to find the March of Dimes presenting itself. You may have been confused by many requests for giving but you gave your dimes, and as a result of it the Salk polio vaccine was born. Had you not done so, this vaccine would never have become a reality because it took 20 million dollars worth of research to produce it. But by so giving, you proved that you could not simply write a single check and with one stroke of your pen, discharge all responsibility to your fellow men. By the same token, we must learn that we cannot write a single check to pay our taxes and with one stroke of our pen, discharge all responsibility to our university—to medicine—to higher education.

Emergency Planning

Emergency planning on the part of the individual and the family can be a very definite part of school health programs. Any major disaster can create consequences which definitely affect not only the school child, but also his family.

Coping with such situations is the primary objective of the Michigan Rural Defense office. This is strictly an educational undertaking and is concerned with all rural people, as well as towns up to the size of 10,000 population. This office is interested in three particular items: (1) pertinent facts concerning major disasters, (2) methods of shelter and preparation to be used by families and communities, (3) encouraging individuals and families to become acquainted with the agencies in their community which are concerned with major disasters.

Emergency planning should cover all imaginable facets such as medical self-help, emergency food supplies, specific duties for each member of a family, emergency transportation facilities, power and water supply, preservation of food and feed, post disaster cleanup, et cetera.—V. L. STINE, Rural Defense Educational Coordinator. Given at the 1963 Michigan Health Council State Conference.

The Saginaw Perinatal Mortality Study

A. H. Van Derhor, M.D.
D. F. Woomer, M.D.
W. Harrigan, M.D.
C. E. Toshach, M.D.
Saginaw, Michigan

THE SAGINAW Perinatal Mortality Study was introduced in July 1956 and has since studied and evaluated all perinatal deaths occurring in Saginaw County, Michigan.

The objectives of the study are:

1. To evaluate the level of maternity and newborn care in the community.
2. To determine the cause of death and point out preventable factors.
3. To improve prenatal, obstetrical and early postnatal care.
4. To stimulate local interest in the problem of perinatal mortality.

This study, like others, was prompted by the fact that the reduction of the mortality rate over the perinatal period has not kept pace with that for the period from one month to one year after birth.

This report reviews all perinatal deaths in the County of Saginaw from July 1, 1956 through December 31, 1961 at the three medical and one osteopathic hospitals. All hospitals in the County of Saginaw are included in the study so that all socio-economic levels of the community are represented. It must be emphasized that this study was never a competitive drive between hospitals but rather a community effort to stimulate interest, and to improve prenatal, obstetrical and postnatal care.

Saginaw County has a population of slightly over 190,500. The 1960 census showed the total population to be composed of 89.5 per cent white and 10.5 per cent non-white persons.

Scope of the Study

Perinatal mortality, as treated in this study, includes stillbirths of 20 weeks and over, stillbirth of infants weighing 500 grams or more and death of liveborn infants up to, but not including, the twenty-eighth day of life. This corresponds to the AMA Perinatal Period II and differs from the more commonly used Perinatal Period III in that the latter extends only through the first six days of life.

Method of Study

Each perinatal death, occurring in any of the four Saginaw hospitals, was reviewed by a resident of the department of obstetrics and gynecology of Saginaw General Hospital. The pertinent data were recorded in a special form, now known as the "Michigan Perinatal Mortality Study Form." A quick glance enables the examiner to acquaint himself with all the pertinent facts of the case. A review of each case, at regularly scheduled meetings, attended by specialists, as well as general practitioners, allowed the cause of death to be determined, preventable factors to be indicated and discussed and areas of improvement to be suggested. The criteria for preventability imply an optimum of professional skill, patient cooperation and hospital care.

The Michigan Department of Health provided financial support and assistance in carrying out the statistical operations of the project.

Statistical Data

Table I shows the grand totals. The total number of births in the Saginaw hospitals from July 1, 1956 through December 31, 1961 was 30,178, of which 25,763 were white, 4,415 non-white. The overall perinatal mortality over this period was 31.9 per 1000 births. The fetal death ("stillbirth") rate was 14.6 per 100 births, the neonatal death rate was 17.7 per 1000 live births.

Table II shows these rates for the non-white groups. Significantly higher rates were found; a total perinatal mortality rate of 41.9 per 1000, a fetal mortality rate of 21.1 per 1000 and a neonatal mortality rate of 20.6 per 1000.

From the Department of Obstetrics and Gynecology, Saginaw General Hospital, Saginaw, Michigan.

This study was possible through the cooperation of Dr. Goldie Corneliuson of the Maternal and Child Health Division of the Michigan Department of Health.

In Table III, the perinatal death rate in illegitimate birth is demonstrated. The total number of illegitimate births in our series was 1101. In this group, 71 perinatal deaths occurred, which gives a perinatal mortality rate of 64.4 per 1000, twice that of the overall perinatal mortality rate.

Table IV shows a summary of the causes of fetal deaths. A division is made between those occurring before and after labor had ensued. A determination of the cause of death was made by analyzing information obtained from the chart, from autopsy reports and from gross and microscopic examination of the placenta. Not infrequently did our decision as to the cause of death differ from the one quoted on the death certificate.

Cord and placental conditions included abruptio placentae, placenta previa, placental infarct, placental insufficiency, cord obstruction and similar conditions. They accounted for 38 per cent of all fetal deaths. Maternal conditions were the cause of fetal death in 20 per cent of all fetal deaths. Maternal diabetes was a cause for fetal death in 20 cases and accounted for 4.6 per cent of all fetal deaths. Maternal infections, debilitating disease and toxemia of pregnancy were grouped under the heading of this condition. Forty-seven cases of erythroblastosis represented 11 per cent of all fetal deaths. Congenital anomalies incompatible with life were encountered in 30 cases. Birth injuries and difficulty in labor with malposition of the fetus, with abnormalities of the forces of labor, with abnormalities of organs or tissues of the pelvis, resulted in the death of 25 (6 per cent) of the unborn infants. The 79 cases listed as miscellaneous and unspecified were mainly cases where the actual cause of death could not be determined. Of interest in this group was a case of a Wilm's tumor with extensive metastasis which led to death *in utero*.

Of all fetal deaths, 78 per cent occurred before labor had started, 22 per cent during labor.

Table V gives a summary of the causes of neonatal death. This is broken down according to time, in hours and days, after birth that the death occurred. Note that 34 per cent of all neonatal deaths occurred within the first six hours of life. By the end of the first 24 hours, 58 per cent of all neonatal deaths had occurred, while in the last three weeks of the perinatal period only 8 per cent of the total deaths takes place.

Birth injuries grouped together and not broken down into naturally occurring and iatrogenic traumata accounted for 28 per cent of the neonatal deaths. Of the 99 congenital anomalies over one-third were of the cardiovascular system.

Postnatal asphyxia and atelectasis represented 16 per cent of the neonatal deaths.

TABLE I. PERINATAL DEATHS
(July 1956 through December 1961)

Total Number of Births—30,178		
Fetal Deaths (Stillbirth)	439	Rate: 14.6 per 1000
Neonatal Deaths	534	Rate: 17.7 per 1000
Not Stated	3	
Perinatal Deaths	976	Rate: 31.9 per 1000

TABLE II. PERINATAL DEATHS IN NON-WHITE PATIENTS
(July 1956 through December 1961)

Total Number of Non-White Births—4415		
Non-White Fetal Deaths (Stillbirth)	95	Rate: 21.1 per 1000
Non-White Neonatal Deaths	89	Rate: 20.6 per 1000
Not Stated	1	
Non-White Perinatal Deaths	185	Rate: 41.9 per 1000

TABLE III. PERINATAL DEATHS IN ILLEGITIMATE BIRTHS
(July 1956 through December 1961)

Total Number of Illegitimate Births	1102
Perinatal Deaths in Illegitmate Births	71 (36 Fetal 35 Neonatal)
Perinatal Death Rate in Illegitimate Births	64.4 per 1000

TABLE IV. FETAL DEATHS BY CAUSE AND TIME OF OCCURRENCE
("Stillbirth")

Cause	Total		Before Labor	During Labor
Cord and Placental Conditions	171	(38%)	136	35
Maternal Conditions	87	(20%)	75	12
Erythroblastosis	47	(11%)	46	1
Congenital Anomalies	30	(7%)	22	8
Difficult Labor and Birth Injuries	25	(6%)	0	25
Miscellaneous and Unspecified	79	(18%)	65	14
Total	439	(100%)	344 (78%)	95 (22%)

Maternal conditions were held responsible for 41 (8 per cent) of the neonatal deaths. If the maternal condition, an incompetent cervical os for instance, or an infectious or debilitating disease of the mother before, perfection with an optimum of professional skill, hospital care and patient cooperation is the criterion by which preventability was judged. Disregarding the ones upon which no judgment could be

TABLE V. NEONATAL DEATHS BY CAUSE AND LENGTH OF LIFE

*Cause	Total		0-6 H	6-24 H	24-48 H	2-7 D	7-28 D
Birth Injuries	152	(28%)	71	36	28	15	2
Congenital Anomalies	99	(19%)	33	16	14	22	14
Postnasal Asphyxia and Atelectasis	86	(16%)	25	29	17	13	2
Infections of the Newborn	35	(7%)	4	6	6	4	14
Prematurity	28	(5%)	15	5	4	3	1
Maternal Condition	41	(8%)	17	13	6	5	0
Hemolytic Disease of the Newborn	23	(4%)	7	6	2	7	1
Miscellaneous and Unspecified	70	(13%)	12	14	19	15	10
Total	534	(100%)	184	125	96	84	44
			(34%)	(23%)	(19%)	(16%)	(8%)

*Infections of newborn one length of life unknown

TABLE VI. VOTING JUDGMENTS

		Fetal Death Before Labor	During Labor	Neonatal Death
Preventable	295 (30%)	115 (34%)	31 (32%)	149 (28%)
Non-Preventable	649	228	47	374
No Judgment	29	1	17	11

Responsibility

Inadequate Prenatal Care	74
Family at Fault	117
Error in Medical Judgment	121
Error in Medical Technique	65

gave rise to premature delivery of the infant, and the infant, because of its immaturity, subsequently died, the maternal condition was held responsible for the infant's demise.

This explains the small percentage of only 5 per cent of death attributed to prematurity, a much smaller number than the 20 to 40 per cent given in most statistics. Although not the sole cause of death, prematurity was associated with a great number of perinatal death. In our series, 640 infants had birth weights of less than 2500 grams and were arbitrarily considered premature. Disregarding the 42 infants whose birth weight was not recorded, prematurity was associated with 68 per cent of all perinatal deaths. Thirty-five infants expired due to infections. As to be expected, these deaths occurred generally later than in any other group. Hemolytic disease of the newborn, finally, was the cause of death in 4 per cent of the cases.

Table VI presents a summary of the judgments upon preventability and responsibility in instances of perinatal death. In voting, each death was considered separately. The assignments of preventability and responsibility was determined by majority vote. In many instances, more than one responsible factor was indicated. Every effort was made to prevent personal factors from influencing the voting. As mentioned passed, usually because of insufficient information, perinatal deaths were voted preventable in 30 per cent of the cases. The highest preventability was found in those perinatal losses occurring before labor, 34 per cent, the lowest in those occurring in the neonatal period, 28 per cent. In the 295 preventable cases, a total of 377 responsible factors were indicated to have contributed to the perinatal loss. Often more than one responsible factor was named. Error in medical judgment was felt to have contributed to the infant's demise in a total of 121 cases (41 per cent); error in medical technique in 65 cases (21 per cent).

In 117 cases (40 per cent), the family was held at fault. Adequate prenatal care could probably have prevented 74 perinatal deaths; that is more than 25 per cent of all the preventable perinatal deaths.

The factor of prenatal care in perinatal mortality is further illustrated in Table VII. This table shows the perinatal losses in relation to birth weight and prenatal care, both for the white and non-white groups. We believe that for a term pregnancy, nine prenatal visits are a minimum; four to eight visits are a minimum for pregnancies terminating with the delivery of an infant weighing from 1500-2500 grams and one to three visits should be considered a minimum for those with infants up to 1500 grams. The pregnancies with inadequate prenatal care are seen above the dark line

in Table VII. Disregarding those where either the number of prenatal visits or birth weight are unknown, a total of 64 (10 per cent) of the white patients and a total of 61 (31 per cent) of the non-white patients

TABLE VII. PRENATAL VISITS AND BIRTH WEIGHTS

Prenatal Visits	Not Listed	0-1500	1500-2500	Over 2500
White				
None	1	9	1	1
1-3	2	48	8	6
4-8	16	182	78	39
9 and Over	13	22	69	139
Elsewhere	1	3	1	0
Unknown	4	36	23	24
Non-White				
None	0	19	6	6
1-3	1	21	6	6
4-8	1	34	21	18
9 and Over	0	5	9	24
Unknown	3	27	12	11
Elsewhere	0	0	0	0

TABLE VIII. CAUSES OF FETAL DEATH AND PREVENTABILITY
Total Preventable Fetal Deaths 35 Per Cent

Cause	Preventable	Non-Preventable	No Judgment
Cord and Placental Conditions	32 (19%)	135	4
Maternal Condition	67 (77%)	19	1
Congenital Anomalies	0 (0%)	28	2
Erythroblastosis	13 (28%)	33	1
Difficult Labor and Birth Injuries	17 (68%)	7	1
Other Causes and Ill Defined	16 (20%)	54	9

TABLE IX. CAUSES OF NEONATAL DEATH AND PREVENTABILITY
Total Preventable Neonatal Deaths 28 Per Cent

Cause	Preventable	Non-Preventable	No Judgment
Birth Injuries	40 (26%)	110	2
Congenital Anomalies	11 (11%)	86	2
Postnatal Asphyxia	22 (26%)	60	4
Maternal Condition	18 (44%)	22	1
Infections of Newborn	26 (74%)	9	0
Prematurity	9 (32%)	19	0
Hemolytic Disease of Newborn	8 (35%)	15	0
Other Causes and Ill Defined	15 (21%)	53	2

received inadequate prenatal care. We realize that an adequate number of prenatal visits does not necessarily indicate good prenatal care, so that inadequate prenatal care is undoubtedly associated with an even larger percentage of perinatal deaths.

Table VIII indicates the causes of fetal deaths and their preventability. A total of 35 per cent were judged to be preventable. The preventable percentage is indicated for each condition. The highest percentage of preventability was found in those deaths attributed to maternal conditions. This group included maternal diabetes, of which 18 (90 per cent) out of a total of 20 cases were considered to have been preventable by good diabetes control and/or early delivery.

Table IX gives the causes of neonatal deaths and the number of each group judged to be preventable. Of all neonatal deaths, 28 per cent were thought to be preventable. Death caused by infection in the newborn was thought to have been preventable in 74 per cent of the cases. Failure to do an exchange transfusion or permitting the continuation of the pregnancy were the main errors made in the preventable cases of hemolytic disease of the newborn. No or inadequate resuscitation of the newborn was the main reason for the death of 26 per cent of the infants where postnatal asphyxia and atelectasis was the cause of death.

Conclusions

Only a few of what we believe to be the most important factors have been brought out in this report. Through the use of our IBM card registry system, cross comparisons can be made against myriads of factors. Although it has not been brought out in the main report, which shows the results of our five-year study, we believe it important to mention that the year-to-year perinatal loss rate remains relatively unchanged. This despite the fact that an increasing physician's awareness of the problems leading to peri-

natal losses, has developed as a result of our study. In an attempt to find a reason for this, the 1950 and 1960 census figures for Saginaw County are shown in Table X. During the 10-year period covered by garded, the premature salvage was 90.7 per cent, an excellent record for which the pediatricians and nursery personnel can be commended. In other words, the prevention of prematurity and its resultant peri-

TABLE X. U. S. CENSUS FIGURES SAGINAW COUNTY, MICHIGAN

	1950	1960
White	144,332 (94.1%)	170,723 (89.5%)
Non-White	9,183 (5.9%)	20,029 (10.5%)
	153,515 (100 %)	190,752 (100 %)

these figures, it can be seen that there has been a disproportionate increase of the non-white as compared to the white patients, and it is well known that the factors of illegitimacy and poor antenatal care are much higher in this group. Whereas the non-white compose 10.5 per cent of the total population, they account for 19 per cent of all perinatal deaths. The fact therefore that the perinatal mortality rate has remained stable, may be interpreted as an improvement.

Finally, the factor of prematurity deserves some consideration. Of all perinatal deaths in our series, 68 per cent were associated with prematurity. At the same time, if infants under 1,000 grams were disre-

natal loss lies, not in the treatment of the immature infant, but in the proper management of the obstetrical patient. Maternal factors have been shown to be the underlying cause in 20 per cent of the fetal and 8 per cent of the neonatal losses. This large perinatal loss is preventable in many instances when adequate prenatal care, early recognition and treatment of the maternal condition based on sound medical judgment is carried out. This implies better community cooperation and lay education, improved socio-economic status in the non-white groups, optimal medical care, sound practice and application of known factors, as well as continuing research.

Routine Choledochotomy with Cholecystectomy

(Continued from page 753)

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Maxillary Extension of Retinoblastoma

H. L. Hubinger, D.D.S.
Robert Bucklin, M.D.
Saginaw, Michigan

THE RETINOBLASTOMA is a primary intramedullary tumor which arises from the medulla-blast of the non-supporting elements of the nervous system, or the neurocyte. It is a tumor of early childhood arising from the neuroepithelium of the retina. It is sufficiently differentiated to justify a specific name rather than a general one, such as neurocytoma.[2]

Case Report

The patient was a three and one-half-year-old boy, who complained of pain in his right upper jaw. The clinical nature of the swelling was such that the child was referred to us for examination by their family physician and dentist (Fig. 1). The parents related a history of right eye enucleation about one year ago.

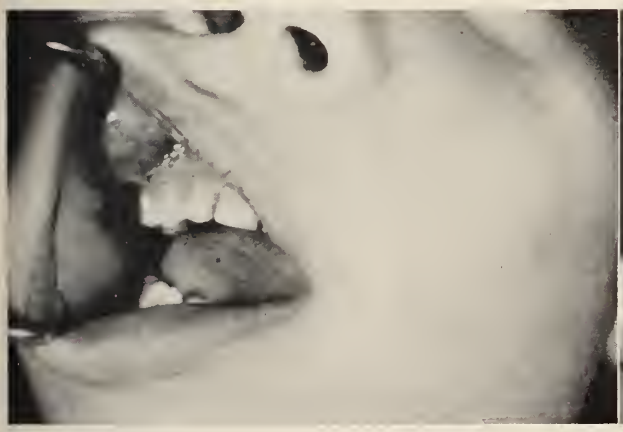


Fig. 1. Photograph of tumor of the right muco-buccal sulcus area of maxilla.



Fig. 2. Dental radiographs of the cyst-like lesion of the right maxilla.

Histologically, the tumor shows some of the characteristics of neurocytomas in other locations, particularly rosette formation, perivascular clustering, and the tendency to necrosis.[2] Most typical is the cellular arrangement of the closely-packed round cells, neuroblasts or retinoblasts, and the rosette or pseudorosette radia arrangement of the cells around blood vessels.[3]

The growth extends along the optic nerve and in about 10 per cent of all cases reaches the intracranial cavity in spite of enucleation.[4]

The dental radiograph (Fig. 2) revealed a radiolucent area of considerable size of the right maxilla involving the roots of the erupted deciduous teeth. The dental follicles of the two permanent bicuspid teeth were completely destroyed or missing. The destruction of bone and especially tooth structure, as shown by the radiograph, is somewhat suggestive of malignant growth rather than benign cyst.

Under general anesthesia in our office, a biopsy of the lesion was done. It was found that the central portion of the tumor was cystic in nature rather than solid. The microscopic examination revealed that beneath the surface squamous epithelium there was a well vascularized fibrous stroma. In the deeper portions of the stroma, there were sheets of poorly dif-

Doctor Hubinger is Oral Surgeon at Saginaw General Hospital, St. Luke's Hospital, and St. Mary's Hospital, and Veterans Administration Hospital, Saginaw, Michigan.
Doctor Bucklin is Pathologist at St. Mary's Hospital, Saginaw, Michigan.

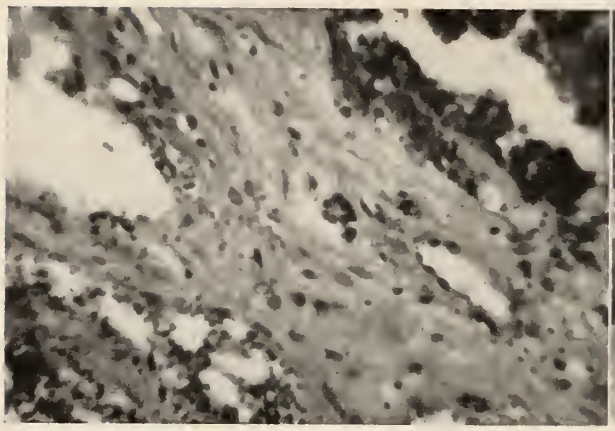


Fig. 3. Low power microphotograph of the tumor showing closely packed retinoblasts.



Fig. 4. Low power microphotograph of the tumor showing one area of rosette formation.

ferentiated cells of epithelial origin (Fig. 3), which had a distinct tendency to surround small blood vessels (Fig. 4).

Discussion

It was subsequently determined that the original lesion of the eye was a retinoblastoma. The rosette formation of epithelial cells about blood vessels in the tumor is typical of retinoblastoma. While the tumor is capable of extending into adjacent tissues early, this case is presented because maxillary extension is unusual. The child expired some months after this procedure and as a result of his tumor metastasis.

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Air Pollution

A subject that is getting more-than-average attention medically is air pollution. The Council on Scientific Assembly of the AMA devoted a half-day of discussion to this problem at the Los Angeles Clinical Meeting, and a few weeks later the U. S. Public Health Service sponsored a three-day National Conference on Air Pollution in Washington.

When physicians and their patients learn that the air over many metropolitan areas and towns contains pollutants potent enough to dissolve automobile finishes, stunt the growth of plants, corrode metals, and even etch crevices in stone, they have cause for concern about what that air is doing to their bodies.

Polluted air is a health hazard. It is linked with lung cancer, chronic bronchitis, asthma, emphysema, and heart disease.

Technology has given Americans the means of controlling many of the sources of air pollution; time and more knowledge will enable us to control still others. But a serious lag exists in the application of control measures now available.

Diabetes in Pregnancy

Experience in Three General Hospitals in Saginaw

John S. Harris, M.D.
Donald F. Woomer, M.D.
Laurence Bruggers, M.D.
Saginaw, Michigan

IN RECENT YEARS there has evolved a more or less complex and sometimes controversial pattern for the management of the pregnant diabetic, or, if you prefer, diabetes complicating pregnancy. But, the two must be considered together. Neither is more important than the other. Our study parallels several others of a similar nature[5,9,14,18,22], which gives us an opportunity to appraise our results in the light of these.

The study is retrospective in nature, and includes cases handled by a variety of men, including generalists and obstetricians, besides being taken from three different hospitals, and, therefore, a certain lack of control of therapy is present. Jones, in recently reporting a fetal mortality of 28 per cent in a setting very similar to ours, commented on this factor of lack of uniformity in the series:

"There is no desire to make the fetal salvage look good. This unvarnished account of rather mediocre results seeks to answer two questions: What kind of diabetic women lose their babies; and under what circumstances? Statistics are a tool to pinpoint trouble spots where corrective measures may be intelligently applied."

Methods

The records of all pregnancies with diagnoses of diabetes, "prediabetes," or on whom a glucose tolerance test was done in the hospital, were reviewed. Three general hospitals in Saginaw were involved: Saginaw General, St. Luke's and St. Mary's. The study covered a period of nine years, between January 1, 1954 and December 31, 1962. The standard oral glucose tolerance test was the one that was used, and was interpreted as abnormal by two or more of the following criteria: FBS over 110 mg/100 ml, half hour of over 160 mg/100 ml, one hour over 140 mg/100 ml, two hour over 120 mg/100 ml and three hour over 110 mg/100 ml. All cases were graded by White's Classification from A to F, where:

Class A includes those with an abnormal glucose tolerance test, or subclinical diabetes,

Class B includes those with onset of diabetes in adult life, of less than 10 years' duration and in whom vascular damage is unlikely,

Class C includes those whose diabetes began at ages 10-19 or who have had diabetes for 10-19 years and in whom latent vascular disease may be present.

Class D includes those with diabetes of greater than 20 years' duration or whose age of onset was below 10 years, and in whom the earliest vascular lesions can be demonstrated,

Class E includes those with advanced calcification in pelvic vessels and retinopathy and,

Class F includes those with albuminuria in the absence of infection or Kimmelsteil-Wilson disease.

Some recent reports[3,16,21] have tried to subdivide what is commonly known as "prediabetes" into various categories such as suspected prediabetes, latent or subclinical, and gestational diabetes, but there is, as yet, no agreement on criteria for differentiating these different types if, indeed, there is any actual difference. We placed all of these, unless the patient was on insulin or diet therapy, in White's Class A.

The minimum age of viability was set at 28 weeks or 2 pounds, 3 ounces, which is in general the agreed limit. Any pregnancy terminating with a pre-viable infant was excluded from the series, as were all abortions and all Class A diabetics, except where specifically mentioned. The diagnosis of toxemia was included in the study in cases in which all of the classic triad of edema, hypertension, and albuminuria was found plus certain cases in which one or more of these signs had been controlled prior to admission and the diagnosis made in the attending physician's office.

Results and Observations

There were 166 pregnancies in 80 diabetic women from a total of 40,000 deliveries in the nine years studied for an incidence of one diabetic in every 397 deliveries. There was one set of twins, bringing the

Doctor Harris is Resident in Obstetrics and Gynecology at Saginaw General Hospital, Saginaw, Mich.

total number of fetuses to 167. The number used for calculating fetal survival was 104, representing the total fetuses minus the pre-viable infants, abortions, and Class A diabetics.

TABLE I - MISCELLANEOUS DATA

Pregnancies	40,000
Patients—Clinical Diabetics	80
Pregnancies in Diabetics	166
Twins (Set of)	1
Total fetuses	167
Incidence of Diabetics in Pregnancy	1:397
Primigravidas	15
Multiparas	65
White Class A	50
Total pregnancies—excluding Class A, abortions, and pre-viable	104

There were 13 abortions for an incidence of 12.5 per cent (Table II). This is slightly above the reported incidence of 4 to 9.2 per cent in diabetics and around 10 per cent in non-diabetics and the excess is explained by the fact that this figure also includes the pre-viable infants. One of the two therapeutic abortions was done at six weeks because of advancing complications of diabetes in the mother. The other was done at 14 weeks in a woman with retinal vascular change, hypertension, and evidence of severe renal damage, on whom a tubal ligation had been previously done. Six had malformations for an incidence of 6 per cent, comparing with a reported incidence of 2 to 9 per cent. Polyhydramnios was noted in three per cent, a figure which is probably unrealistically low. Other series report 4.1 to 48 per cent incidence of polyhydramnios.

TABLE II - FETAL COMPLICATIONS

	Number Cases	Incidence	Reported Incidence
Abortions (includes pre-viable)	13	12.5	4-9.2
Spontaneous	11	9	
Therapeutic	2	2	
Viable Premature	16	14	
Malformations	6	6	2-9
Polyhydramnios	3	3	4.1-48

Fetal Results.—The total fetal survival was 79 per cent, including eight viable prematures and 74 mature infants. Stillbirths accounted for 13 of the 22 perinatal deaths, the remaining nine being neonatal deaths.

Two of the six infants with anomalies died shortly after birth. One of these was born at 34 to 36 weeks with congenital heart disease. The other was an anencephalic and was one of a pair of twins born at 36 weeks.

TABLE III - FETAL RESULTS (GENERAL)

	Number Cases	Percent
Salvage		
Total	82	79
Premature	8	8
Term	74	71
Wastage		
Total	22	21
Intrauterine	13	12.5
Neonatal	9	8.5
Premature	8	8
Anomalies	2	2
Suppurative pleuritis and pericarditis, hyaline membrane and lipid depletion of adrenal cortex	1	

Maternal Complications.—There was an identical incidence of toxemia and ketoacidosis. Both of these complications occurred in 31 cases for an incidence of 30 per cent. Most of the cases that manifested toxemia did not have ketoacidosis although there was some overlap between the two groups. Three patients had both toxemia and ketoacidosis. Fetal survival in those patients with toxemia was better than the overall survival (Table IV), while the survival in those who had ketoacidosis during the pregnancy was not so good (71 per cent). It is significant that, of all the perinatal deaths, nearly two thirds (64 per cent) occurred in this combined group of toxemia and ketoacidosis. Within this figure of 64 per cent, again, there is some overlap, but with that considered, it remains a significant figure.

There was no incidence of maternal mortality.

Antepartum infections occurred in ten patients for

TABLE IV - INCIDENCE AND EFFECT OF TOXEMIA AND KETOACIDOSIS

	Number Cases	Percent Incidence	Percent Reported Incidence	Perinatal Death	Percent Survival	Percent Wastage
Toxemia	31	30	3-59.5	5	84	16
Ketoacidosis	31	30	0-28.7	9	71	29
Percent of All Perinatal Deaths						
Toxemia—(22 total perinatal deaths)				5		23
Ketoacidosis—(22 total perinatal deaths)				9		41
						Total 64

an incidence of 9.6 per cent. One patient had a furunculosis and the remaining nine infections were in the form of pyelitis, an incidence of 8.7 per cent or two to four times the incidence of 2 to 4 per cent occurring in pregnancies not complicated by diabetes.

double that in cesarean section is borne out in other studies as well. Subdivision of perinatal mortality by parity reveals a marked contrast of 42 per cent in primigravidas delivered vaginally and no mortality in those delivered by cesarean section (Table VI). This

TABLE V - FETAL SALVAGE BY WHITE'S CLASSIFICATION

Class	Number Cases	Perinatal Deaths	Fetal—Salvage			Perinatal Mortality
			White	Present Study	McLendon & Bottomy	
A	44	13	100	70	77.2	30
B	62	10	92	84	78.2	26
C	33	10	86	69	46.7	31
D	6	1	85	83	82	17
E	1	0	76	100	—	0
F	2	0	59	100	100	0

TABLE VI - MODE OF DELIVERY AND PARITY

	Number Cases	Percent of Births	Perinatal Loss	Percent Salvage	Perinatal Mortality
Cesarean Section	41	40	5	88	12
Primigravidas	3		0	100	0
Multiparas	38		5	87	13
Vaginal Deliveries	62	60	16	74	26
Primigravidas	12		5	58	42
Multiparas	50		11	77	23

Classification.—Since White's proposed "Pregnancy Risk Classification," there have been a large number of studies in which her scheme has been used. These have not borne out her results.[14,17] Her results showed a progressively decreasing survival rate as the severity of the illness increased (Table V). McLendon and Bottomy,[14] in a series very similar to this one, had the following survival rates: A=77.2, B=78.2, C=46.7, D=82 and F=100 per cent (one case), results which parallel ours rather closely. Another interesting observation from their series as well as our own is the similarity between the salvage rates in Class A and Classes B through D. This will be developed more fully later in the paragraph on preclinical diabetes. Because of small numbers of cases in Classes E and F, these results are not considered significant.

Mode of Delivery.—Forty-one patients were delivered by cesarean section for an incidence of 40 per cent. This is a significantly lower incidence than that cited in most reports,[8,14,17,22] although Crenshaw[5] had a 6 per cent incidence of cesarean sections in his series with a perinatal mortality rate of 33 per cent. There were 62 vaginal deliveries for 60 per cent of the total. Comparison of the perinatal mortalities reveals a rate of 12 per cent in the section vs. 26 per cent in the vaginal deliveries. The observation that perinatal mortality in vaginal deliveries is roughly

perinatal mortality rate carries a little different significance, however, when the individual cases making up the figure are examined. Four of the five fetal losses in the primigravidas delivered vaginally were stillbirths. Three of these were delivered at 40 weeks. In one, fetal heart tones were lost 18 hours prior to delivery; in the second, fetal heart tones were lost one month prior to delivery, and in the third, fetal death had occurred at 34 weeks during an episode of acidosis. The fourth stillborn was delivered at 37 weeks. The other fetal loss in this group occurred at 30 weeks as a result of prematurity and pulmonary atelectasis.

Time of Delivery and Birth Weight.—Birth weight and the time of delivery are, of course, closely related, and Figure 1 shows the general trend that would be expected, with increasing birth weights as term is approached. Another observation from this graph is the rather sharp division between the neonatal deaths, which occur up to the 36th week and the stillbirths, which occur after that time.

The perinatal mortality in relation to birth weight (Table VII) reflects this same division, with higher mortality rates at the light and heavy end of the spectrum. The optimal survival rate occurred in the 6.5 to 7.5 pound weight group, an observation which has been duplicated in other series.[14,18]

Discussion and Conclusions

As was stated in the opening paragraph, statistics are a tool by which trouble spots can be detected and corrective measures intelligently applied. In the following paragraphs the "trouble spots," which arose out of this study, will be considered and compared to the experience of others from the literature.

The subject that deserves consideration before anything else is that of "prediabetes." Let me start by outlining the history of one patient from the series:

Mrs. B.W., age 20, a gravida 5 para 4, was admitted in 1959 at beyond 40 weeks. She was delivered of an 11 pound, 8 ounce stillborn infant, cause undetermined. In 1960, she was admitted at 40 weeks and delivered an 11 pound, 5 ounce stillborn infant and on this admission had a fasting blood sugar which was 115 mg. per cent but no glucose tolerance test or treatment. In 1961, a 10 pound, 12 ounce stillborn infant was delivered and no blood work. In 1962, a 12 pound, 7 ounce stillborn child was delivered, and this time, a glucose tolerance test showed elevation into the diabetic range.

The likelihood that abnormal carbohydrate metabolism played a role in these stillbirths is very good. As early as 1944, before the concept of prediabetes originated, it was shown statistically[15] that perinatal mortality in pregnancies occurring five years before the onset of frank diabetes was five times the normal incidence. Several reports since then,[8,14,18] including our own, have shown the fetal loss in "prediabetics" to be identical to that in diabetic women. I have been referring to prediabetes in quotation marks. The strict definition of this term refers to an abnormal carbohydrate metabolism occurring before or leading up to the onset of frank clinical diabetes mellitus. This term, therefore, can be applied only retrospectively, after

TABLE VII - FETAL SALVAGE IN RELATION TO WEIGHT

Weight	Number Cases	Perinatal Death	Percent Salvage	Percent Perinatal Mortality
2# 3 oz. — 5# 8 oz.	16	8	50	50
5# 9 oz. — 6# 8 oz.	19	1	95	5
6# 9 oz. — 7# 8 oz.	19	0	100	0
7# 9 oz. — 8# 8 oz.	16	2	87.5	12.5
8# 9 oz. — 9# 8 oz.	16	5	69	31
9# 9 oz. — 13# 3 oz. (largest baby)	17	5	70	30

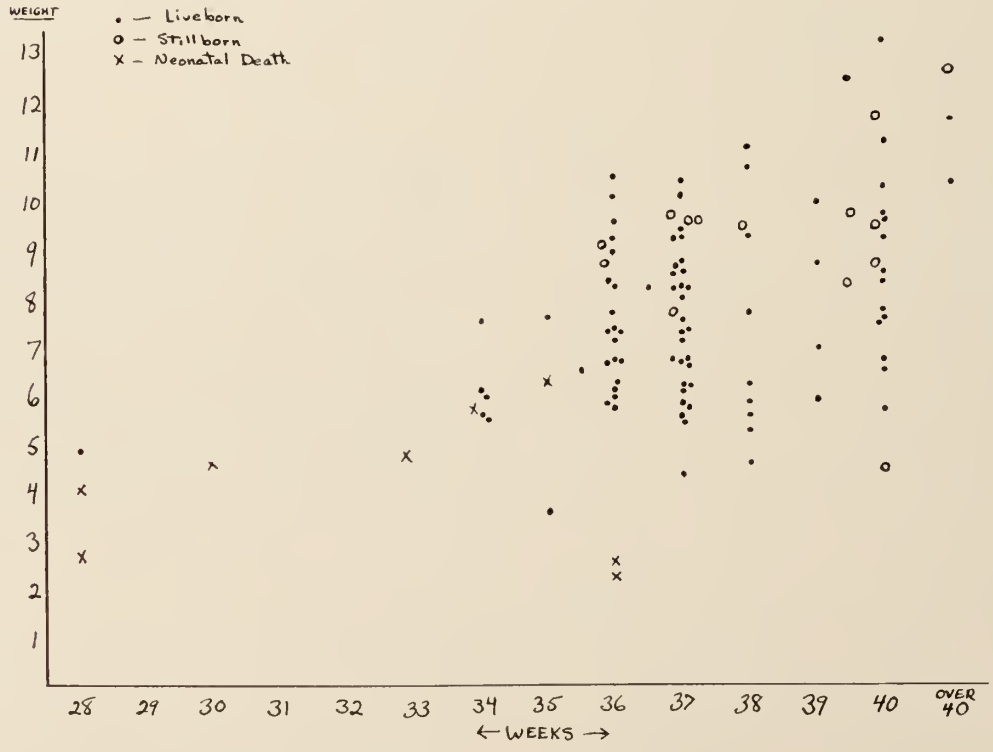


Fig. 1. Time of delivery, weight and fetal results.

the diagnosis of frank diabetes is made. One certainly cannot talk of a "prediabetic glucose tolerance test." Of the person with an abnormal glucose tolerance test arising in pregnancy, the most one can say is that she is more likely to develop diabetes mellitus, and should remain as suspect until that diagnosis can be made. Much of the loss in Class A occurred in unsuspected cases in our series. In 50 per cent of all the Class A diabetics, the diagnosis was made in the puerperium, and in this group diagnosed post-partum, the perinatal mortality was 50 per cent. There were 12 perinatal deaths in all of the Class A diabetics and 10 out of the 12 occurred in the group diagnosed post-partum. The fact that such a high percentage of deaths were in the group not diagnosed until the puerperium exposes a potential area for reduction of perinatal mortality. This, of course, would depend on prospective rather than retrospective diagnoses, in turn dependent on a high degree of suspicion. Shlevin and Pedowitz suggested glucose tolerance tests in those cases with a history of large babies, previous unexplained stillbirths, family history of diabetes mellitus, recurrent pre-eclampsia, previous glycosuria or glycosuria in current pregnancy, a fetus too large for the period of gestation, and in habitual aborters, even though half of these will be normal. What can be done once the abnormal test is turned up? Carrington,[2,3] and her group follow each patient with two-hour post-prandial blood sugars once a week and put the patient on an 1800 to 2200 calorie diet if the two-hour level is between 140 and 170. They give insulin to those above 170 who do not come down to 140-150 on diet alone. Those with two-hour blood sugars between 120 and 170 are allowed to go to term, if there are no complications, and those with two-hour blood sugars above 170 have a vaginal examination weekly from the 36th week and induction as soon as the cervix is favorable. In any case, if the two-hour blood sugar is rising or if hydramnios or pre-eclampsia persist, the patient is treated and delivered as soon as induction can safely be done. Welsh uses a similar program of 1600-2000 calorie diet and 10-15 units of NPH insulin when necessary.

The mode and time of delivery remain a controversial subject. Much of the problem of optimum time of delivery lies in whether to deliver early with the risk of prematurity and atelectasis or later, with the inherent risk of stillbirth. Obviously somewhere in between would be best. And, in fact, this tenet most likely stands in the best agreement of any of the principles of management of pregnancy in the diabetic. It is fairly generally held that delivery at around thirty seven weeks yields the best results. Intimately related to time of delivery are birth weight and mode of delivery. The best results apparently occur in those between 6.5 and 7.5 pounds. This has led to the use of estimated fetal size of 3500 gm. as the criterion for proper time of delivery by Reis and his group.[18] Unfortunately, there is no accurate method for determining fetal weight before delivery. Another point, which bears keeping in mind, is that weight alone is not a good measure of maturity in the offspring of a diabetic mother, and a child, which is mature by the usual standards of weight, may be much less mature because of the edema and increased fat deposition, which is seen in these babies. No conclusion can be drawn from our statistics as to mode of delivery, even though comparison of perinatal mortality in cesarean section and vaginal delivery would seem to indicate cesarean section to be the mode of choice. The several cases presented show that there are a large number of variables, which alter the significance of the statistics. It appears in other reports in the literature that many places which report high fetal survival rates in conjunction with high section rates also have standardized treatment programs with reduction of other variables to a minimum. Pedowitz and Shlevin,[17] however, reported a decrease in perinatal mortality from 22 per cent to 8.2 per cent associated with an increase of the cesarean section rate from 40 to 63 per cent, keeping other variables constant.

As far as maternal morbidity is concerned, ketoacidosis, toxemia, and pyelitis stand out as the major "trouble spots." The occurrence of ketoacidosis has been known to be associated with a very high fetal mortality for some time.[17] It is in this area that the so-called team management of the pregnant diabetic, with obstetrician and internist working together, probably has its greatest benefits. Toxemia, of course, has its own deleterious effect on fetal survival. It is reasonable to expect an increased incidence of at least part of the triad because of the vascular degenerative changes that result from diabetes mellitus. Cobley and Lancaster from Australia feel so strongly about the influence of pre-eclampsia in diabetics, that they favor delivery within 72 hours of its appearance.

The two to four-fold increase in pyelitis in pregnant diabetics is a startling and significant finding. Kass,[22] did a study comparing "significant bacteriuria" (*i.e.*, more than 100,000 colonies per ml. urine) in hospitalized pregnant women, pregnant out-patients, and normal, non-pregnant college women. He found significant bacteriuria in 7 per cent of the hospitalized

group, compared to 4 per cent in the out-patients and only 0.5 per cent in the controls. Younger, Rees and White,[22] in a follow-up to Kass's work, studied 65 pregnant juvenile diabetics, and found a 15 per cent incidence of significant bacteriuria. With these figures in mind, it would seem that much could be done in these cases through diagnosis and treatment by maintaining a high degree of suspicion, and through prevention, by sparing use of the urethral catheter.

Summary

Records of 166 pregnancies, occurring in diabetic women from three general hospitals, were reviewed and analyzed. Abortions, pre-viable infants and preclinical diabetics were excluded from the study. Total fetal survival rate was 79 per cent. Sixty-four per cent of the perinatal deaths occurred in those with toxemia or ketoacidosis. Perinatal mortality in "prediabetics" (excluded from the remainder of the study) was nearly identical to that in the known diabetics. Pyelitis occurred in 8.7 per cent, roughly two to four times the incidence in non-diabetic pregnancies. Perinatal mortality in those delivered by cesarean section was 12 per cent and 26 per cent in those delivered vaginally. The optimum birth weight was 6.5 to 7.5 pounds, with a survival of 100 per cent. All neonatal deaths occurred before 37 weeks and all stillbirths occurred from the 36th week on. The significance of these figures is discussed.

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About Retirement

It may never come. Not if one American tannery executive has his way. Five years ago, at the International Shoe Company tannery near St. Louis, Vice-President R. G. Richards decided that prejudice against hiring older workers was nonsense.

To reverse it, he decided to hire only men who could prove they were over 45 years. The result: "Men in this age bracket are reliable, do their work well, and have more mature judgment than younger men," says Richards, whose company is doing fine. His employees range from 45 up to 85, and he has one 80-year-old who recently asked for a transfer to another job in the plant "with more of a future."

The Private Practitioner And Tuberculosis Control

Louis F. Hayes, M.D.
Gaylord, Michigan

OVER the past few decades the private practitioner has been nearly divorced from the diagnosis and treatment of tuberculosis. This has resulted from a number of factors, but economics have played a dominant role. Because of the contagious nature of the disease, the need for isolation to prevent further spread and the lengthy treatment period needed to reach a noncontagious stage, the cost has become prohibitive for the average person of modest income. Accordingly, responsibility for this problem has been assumed by governmental units, financed by tax revenues, operative through Public Health Departments.

The initial success in reducing the incidence by isolation led to an effort to find cases early enough to isolate them before the disease was communicated to others. This resulted in large scale case-finding efforts such as school skin-testing programs and photoroentgenographic screening, both on hospital admissions and by mobile units. Although these techniques had sufficient success to warrant their continued use, they served to remove the private practitioner further from the diagnosis and treatment of tuberculosis.

The advent of anti-tuberculous drug therapy fifteen years ago, followed by pulmonary resective surgery, are other factors that have had a marked influence on the tuberculosis picture. Mortality has rapidly declined (in Michigan, from 17.6 per 100,000 in 1951 to 4.2 in 1961); hospitalization periods have been cut in half (from 1-2.5 years to 0.5-1.5 years); sanatorium populations have dropped (from 4,756 average census in 1951 to 2,420 in 1961).

These remarkable successes have led many people to conclude, prematurely, that the control of tuberculosis has been achieved. This is not the case. Actually, more needs to be done to effect *control* of the disease and our ultimate goal must be to eradicate it, or at least match the success attained in the suppression of smallpox.

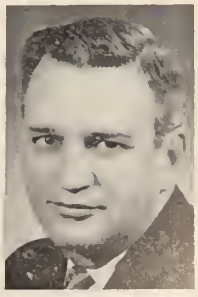
Two problem areas in control are apparent: First is the large reservoir of tuberculosis infection from which new cases could develop and second is the real threat of recent increases in the rate of drug resistance.

United States Public Health officials have estimated that one in five of the population is infected with the tubercle bacillus. This estimate has been borne out in Michigan, where recent skin-testing programs have revealed an incidence of 22.54 per cent positive reactors in a three-year total of adults tested and a 1.31 per cent incidence in school populations. Since it is likely that many active cases in the future will be reactivation of inactive cases, these represent potential sources of infection for small children.

Dr. James Raleigh, of the American Thoracic Society, has estimated that we now have an 8 per cent incidence of drug-resistant tuberculosis cases. Of these, between 3 and 6 per cent are resistant to the mainstay of drug therapy, isoniazid. This being true, it is conceivable that in the United States we could develop drug-resistant cases at the rate of 6,000 per year. This has led Dr. René Jule Dubos to warn "all biologic experience indicates that we are working against time unless other powerful modes of chemotherapy are developed."

It is apparent, then, that case-finding must be accelerated so that infection may be discovered and treated early. In order to achieve these goals, the private practitioner must be utilized since he is in an ideal position to diagnose cases in the pre-symptom

The Author
LOUIS F. HAYES, M.D.



Doctor Hayes is Chairman of the Subcommittee on the Role of the Private Practitioner in Tuberculosis Control, MSMS Tuberculosis Control Committee. Other subcommittee members are: Paul T. Chapman, M.D., TB Controller, Detroit; Winthrop N. Davey, M.D., University Medical Center TB Unit, Ann Arbor; John L. Isbister, M.D., TB Control Officer, Michigan Department of Health.

stages and to encourage patients to accept treatment, thus preventing spread by reducing the "reservoir of infection."

Because the Tuberculosis Control Committee of the MSMS believed this area to be of urgent importance, it appointed a subcommittee to outline the role of the private practitioner in tuberculosis control today. The report follows:

Report of Subcommittee of the MSMS Tuberculosis Control Committee

I. *Private Practitioner*

The practitioner, having the most frequent contact with the largest number of people, particularly family units, would be in the best position to render the greatest aid in tuberculosis control. Logically, this would be, in both urban and rural areas, the general practitioner. *Pediatricians,* who see a large number of well children for annual examinations, and *internists,* who act as family doctors, would also be of aid in tuberculosis control.

II. *Role*

A. *Diagnosis*

1. *Skin Testing*—Since children are seen frequently in infancy by the general practitioner and pediatrician, and routine immunization of diphtheria, pertussis, tetanus, polio, and smallpox are done at this time, it is recommended that, *during the immunization schedule* (between 6 and 18 months of age) *an initial skin test be done.*

 In the same offices, large numbers of these children are next seen for pre-school examinations, at which time booster doses of the usual immunizations are given. *At this time it is recommended that another skin test be done.*

 After the child enters school, the frequency of visits to the family doctors diminishes sharply—therefore the efficacy of the skin test as a case-finding tool is markedly reduced. However, there still remains a role for the private practitioner. By encouragement of (privately—with his patients, publicly—in community life) and active participation in school survey programs in cooperation with local public health authorities, he can further the goal of tuberculosis control.

 Private practitioners should be encouraged to use the skin test as a tool in differential diagnosis, particularly in vague or chronic illnesses, even though a negative chest x-ray is reported. This is particularly applicable in cases where extra-pulmonary tuberculosis could be present.

 Pediatricians in urban areas who see their patients at intervals for checkups should be encouraged to have interval skin testing programs.

 At the present time, the intradermal test with tuberculin, properly given and interpreted, affords the highest degree of accuracy for case-finding. However, the Tine test, now undergoing comparision testing on a large scale, would, if as accurate, be preferable because of its convenience.

2. *Disposition of Positive Reactors*—An initial chest film should be taken. If this shows disease, the patient should be referred to the nearest tuberculosis treatment center and the local Health Department notified of the diagnosis of a reportable disease. If *negative,* the Health Department should still be notified so a study of contacts can be made and a follow-up plan for the patient be formulated in cooperation with the family physician.

3. *Chest X-rays*—Routine photoroentgenograms on hospital admission and those taken by mobile x-ray units are an excellent tool in the case-finding programs. However, there must be large numbers of people seen in private offices who are not included in these programs. Private practitioners should be encouraged to continue to have a high index of suspicion, particularly in vague chronic illnesses and tuberculin positive patients—and x-ray them. It should be pointed out that comparison with previous films adds a great deal to diagnostic ability and also that any suspicious film can be referred to a tuberculosis facility for consultation.

4. *Sputum Tests*—The fact should not be overlooked that the laboratories of the State Health Department are available for positive bacteriologic diagnosis. Positive reactors with suspicious chest lesions would be logical candidates for this type of study.

B. *Treatment*

1. *For All Active Cases*—Treatment should be given in a tuberculosis facility. This is essential because of the need for isolation and because of the concentration of treatment, particularly with the increased frequency of surgical intervention. This, however, does not eliminate the private practitioner from the care of the patient. In his role as family doctor and friend, he can prepare the patient beforehand for the lengthy hospitalization by giving him and his family a concept of the disease, the modes of treatment, and the length of time necessary for the process. In addition, after discharge the private practitioner can cooperate in the follow-up care of the patient.

2. *Secondary Prophylaxis.* In the case of recent or incidental tuberculin converters, particularly young children with negative chest films, isoniazid could be given on an out-patient basis by the private practitioner. In such circumstances it would be advisable to consult local tuberculosis authorities before instituting treatment.

So once again we turn to the private practitioner—our best hope in increased case-finding. The opportunities presented by the unique personal-contact relationship of the doctor are not equaled by any other technique. The Subcommittee urges the renewed vigilance and vigor of the doctors of Michigan in meeting this challenge. Then we shall be on the way to illustrating the truth of these remarks of Dr. Dubos:

"I do believe that a vigorous effort to detect the spreaders of bacilli, and treat them in such a manner to render them non-infectious, would give the coup de grace to tuberculosis in the United States within a relatively short time."

The Central Credentials Committee

By Roy J. Gerard, M.D., Editor
Saginaw County Medical Society Bulletin

The medical community of any city is healthy if the spirit of co-operation is present and if incentive is not stifled.

We have in Saginaw a medical group which is unparalelled anywhere in Michigan. We have a feeling among doctors which should serve as an example for medicine wherever it is practiced.

General practice is not dying in our community; it is thriving and growing, largely because of the foresight of a group of specialists who saw the need years ago of a formula which would set up a program to help set limits, not necessarily restrictions, on all physicians when they began their practice. Thus, was born The Central Credentials Committee.

In the 1920's and early 1930's, the doctors in Saginaw realized the problem of surgical privileges and Saginaw hospitals needed some kind of management by the hospital staffs. It had been recognized in 1905 when the AMA investigated hospitals and medical schools, that the handling of surgical privileges by hospital management was extremely necessary. One solution was the establishment of "closed" hospitals where excellent standards could be maintained. However, this left the smaller neighboring hospitals stranded without the help of the best trained men of the medical profession.

In Saginaw, the physicians had believed in and followed the philosophy of the "open" hospitals in spite of the fact that "open" hospitals complicates the management of accreditation of existing personnel. Originally this control was placed on the shoulders of the chief of surgery of each hospital; obviously, this was too much for one man who could not know the qualifications of all doctors in the community.

In 1938, it was decided that a committee of two from each hospital, the chief of staff, the chief of surgery, plus

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one pathologist and one radiologist should take over the problem of deciding who was to be given surgical privileges in our community. (Two of these original members are still on this committee.)

The committee's recommendations were made to each hospital but they were recommendations only and their implementation was the responsibility of each hospital. Suggested were three classes of surgery: (1) minor surgery, (2) lesser major surgery, (3) full major surgery.

The same classifications were applied to obstetrics also.

There have been many changes since these inceptions. For instance, after World War II the committee felt that only doctors who had specialized training should be given full surgical privileges, yet there are still possibilities of preceptorship available which would help doctors with minor privileges to receive lesser major privileges if they have the desire, the interest and surgical ability.

It is felt that this plan had served admirably to establish a quality of excellence in Saginaw surgery and obstetrics.

Whether or not this plan was necessary we shall probably never know, but, it is certain that some plan was essential. It was and is part of the inevitable evolution of medical care. We like to think of such evolution as a product of the dedication and progressive thinking of physicians and certainly the profession is credited with steering and providing the leadership in matters pertaining to the constant improvement in the care of the patient.

We must not forget that "the consumer" has been more articulate in his demands for superior care, reduced morbidity, broadened fields of effective therapy and bringing to Saginaw those advances enjoyed not only in other communities of like size but in larger metropolitan areas and indeed the teaching centers of the nation.

It is inevitable that this plan will change, and the role of the generalist in the surgical care of patients may be radically different from what we know it today but as long as such a plan exists there will always be a spirit of cooperation between specialists and generalists and more important the quality of medical care rendered to the patient will improve as its result.

"I will impart a knowledge of the art of my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others." (The Oath of Hippocrates)

Thank You, Saginaw

It has been the custom of The Journal MSMS over the years to "dedicate" an occasional issue to one of the component medical societies in Michigan.

The Journal and the Publication Committee are pleased to devote this issue to scientific articles submitted by members of the Saginaw County Medical Society. Attention is directed to the lead-off editorial which is written by the editor of the *Bulletin of the Saginaw County Medical Society.*

Instrumental in coordinating the special Saginaw material was Robert Bucklin, M.D., a past president of the Saginaw County Medical Society. Assisting him on a special committee were the following Saginaw County physicians: H. T. Caumartin, M.D.; Donald C. Durman, M.D.; Roy J. Gerard, M.D.; Edward F. Kickham, M.D., and Paul R. Noble, M.D.

Once again, thank you, Saginaw County Medical Society, for a job well done.

New Jersey Approach

Funds for New Jersey's Kerr-Mills program to provide medical care for needy aged will be administered through the state's Blue Cross plan. Irving Engleman, state welfare director, said Blue Cross will handle hospital claims for the aged presented to it by county welfare boards and will also provide a master health insurance contract for persons receiving old age assistance.

Annual Report of The Council

The Council met eight times during the year. The deans of the two medical schools in Michigan, the State Health Commissioner and the President of Michigan Medical Service were invited to every meeting, to present reports on matters of mutual interest.

The Council met with special guests including the Board of Trustees of Michigan Hospital Association, the Board of Directors of Michigan Health Council, and the Michigan Crippled Children Commission. Chairmen of certain MSMS committees were invited to make special presentations regarding their committee activities.

A total of eleven days was spent in Council's deliberation, which provided a continuing review of MSMS activities and permitted sufficient time for the preparation of MSMS policy on a multitude of important matters.

Membership

Total membership as of June 30, and as of December 31, from 1935 to 1963, is indicated in the following chart:

Year	*June 30*	*December 31*
1935	3410	3543
1945	4425	4686
1955	5503	6109
1960	6660	6715
1961	6639	6775
1962	6776	7018
1963	6858	

Scientific Activities

One of the most important purposes of MSMS is to advance the scientific knowledge of the medical profession. This scientific work continued in 1962-63 and was of direct benefit to members and through them the patients they serve. Following are the most significant scientific projects:

1. The 1962 Annual Session in Detroit drew a total registration of 3,393, including 2,163 MD's. The scientific program was widely acclaimed, and attendance reached expectation.

2. The 1963 Michigan Clinical Institute continued the successful 8:00 a.m. Clinical Roundtables; also the three evening seminars were well received. Total attendance was 1,985, including 1,084 MD's.

3. Extramural postgraduate courses were presented in 20 cities through the cooperation of MSMS, University of Michigan Medical School and Wayne State University College of Medicine.

4. The Journal of MSMS continued to provide scientific papers by noted Michigan and national medical authorities.

5. Several MSMS committees have offered to furnish scientific speakers to component societies; a 1½ day conference on maternal health was organized by the Maternal Health Committee.

6. The MSMS Presidents Program, approved by the 1960 House of Delegates, focused on scientific activities and cooperative ventures with allied health organizations.

The Journal

Many contributions to medicine were offered through The Journal of the Michigan State Medical Society for 1962-63 in addition to many reports of the various Society activities.

As in the past, various numbers of The Journal have been devoted to specific fields of interest. Diabetes was the subject of The Journal for October, 1962, with Fred W. Whitehouse, M.D., Detroit, as the coordinator. The November, 1962, number contained papers about Heart, with John G. Bielawski, M.D., Detroit, as the coordinator. Postgraduate Study and its progressive program of MSMS medical education activities was the subject for the December, 1962, number with John M. Sheldon, M.D., Ann Arbor, as coordinator.

Following the pattern of former years, the January, 1963, number featured the 1963 Michigan Clinical Institute. Master Surgery was the topic for February, 1963, with R. L. Mustard, M.D., Battle Creek, as coordinator. March, 1963, featured articles about Orthopedics, coordinated by James H. Horvath, M.D., Detroit. The annual Cancer number appeared in April, 1963, with William Bromme, M.D., Detroit, as coordinator. The May, 1963, Journal was about Geriatrics, with Jack Rom, M.D., Detroit, coordinator. The numbers for June and July, 1963, featured material about the 1963 Annual Session and MSMS House of Delegates meeting. August will spotlight the Saginaw County Medical Society, with Robert V. Bucklin, M.D., Saginaw, as coordinator for the articles by Saginaw doctors of medicine.

Constant improvements have been made in the production of The Journal to increase readability and to provide material of maximum interest to every doctor. The mechanical aspects of The Journal have been systematized so that The Journal now is mailed from the printer on the 10th of each month.

One of the interesting innovations during 1962-63 has been the appearance of many guest editorials in The Journal, written by both medical and non-medical leaders in the state. Another innovation has been the development of a special section of The Journal for news reports from the various component societies.

Rounding out THE JOURNAL each month have been many other features such as Editorials, State Society News, Public Relations Advice, Socio-Economic Reports, Legislative Observations, Ancillary News, Legal Opinions, Calendars, Reviews of New Books, and other items.

In recognition of his great service and dedication, The Council in May appointed Wilfrid Haughey, M.D., Editor Emeritus of THE JOURNAL of MSMS.

With the death of Doctor Haughey on July 12, Michigan Medicine suffered a great loss. It will be difficult to replace such a devoted individual.

Finance

All departments are being operated economically in line with fulfillment of the aims and purposes of the State Medical Society. All committees are maintaining their activities within their budget allocations.

The reserve of $57,000 in Government bonds has been maintained with $35,000 of this amount earmarked for the Public Relations Department. The balance of $22,000 in bonds is for the General Fund.

In addition, in 1963 a Savings Reserve account was established and to June 30, $18,874.39 has been placed in a savings account in the Michigan National Bank. This account is retained as a liquid reserve for contingencies so that bond reserves will not have to be sacrificed at unfavorable rates. The policy of debt retirement and maintenance of MSMS headquarters has been continued in 1963 and the debt as of June has been reduced to $80,000, as part of the plan to reduce debt as much as possible during the early months of the year and re-borrow needed funds later in the year when income is low. No additional borrowing is planned until October, 1963. This procedure continues to provide savings of approximately $4,000 per year in interest payments.

Organization Activities

1. Communications with Members. The JOURNAL expanded its coverage of MSMS activities and published more articles of medical socio-economic interest. Council minutes were distributed to component societies and members of the House of Delegates requesting them. Person-to-person communication was enhanced this year by the continuing of Councilor District Conferences, by the holding of eleven State Society Nights where MSMS officers and staff presented a program at the invitation of the component society, and by personal visits of MSMS officers, Councilors, and staff. In addition, the President's Letter, the County Societies Letter, the Economic Bulletin and the Legislative Report were distributed. As a year-end report, all members received a short printed Annual Report of the Michigan State Medical Society.

2. The Annual Seminar (formerly the County Secretaries-Public Relations Conference) was held in Lansing, January 24, 1963. The morning program was entitled "The Physician's Responsibilities in Community Affairs." The afternoon session reported how "Physicians Act to Meet Community Challenges." An overflow crowd attended the Seminar. On this occasion, the MSMS Awards Luncheon was held. (Awardees are listed in the Annual Report of the Awards Committee.)

4. The Annual Residents-Interns-Senior Medical Students Conference was held March 14 during the Michigan Clinical Institute. Highlight of the program was a panel discussion on "Religion and Medicine".

5. Field Services. The MSMS field secretaries and staff have provided extensive individual and component society contact this year. The immediate result was more effective implementation of local, state and national programs and projects.

6. Medical Aid Station at Capitol Building. In cooperation with the physicians of the Ingham County Medical Society, a medical aid station was provided in the Michigan Legislature, staffed by a nurse. MSMS provided necessary funds and local physicians volunteered to provide necessary coverage for emergency or referred calls. The Council expresses its appreciation to the Ingham County physicians who participated in this important liaison project.

7. Workshop for Component Society Executive Secretaries. Two workshops were held this year to improve rapport between component society and State Society staffs. These were informational sessions to increase understanding of mutual problems and goals.

8. Committee on Religion and Medicine. With the establishment by AMA of a Department of Religion and Medicine, The Council created a state committee to cooperate with AMA and component societies in establishing communication between physicians and the clergy to enhance the total care of the patient.

9. Immunization Month. MSMS provided component societies with placards for physicians' offices, designating June as immunization month and urging patients to have their doctor check their immunization status.

10. Annual Washington Visit. As authorized by the 1962 House of Delegates, officers and staff visited legislators and their aides in Washington, D. C. Again, this was an effective and productive liaison meeting. The Council is pleased to note the increased activity of component societies in sending delegations to Washington. A recommendation on this subject follows.

11. Relative Value Study Committee. To provide for a continuing study of the Michigan Relative Value Scale, adopted by the 1962 House of Delegates, The Council appointed a committee to receive suggestions and comments for revision and updating.

Liaison with Governmental Agencies

1. MSMS maintained excellent liaison with offices and agencies of state government through staff and individual physician contact.

2. Insurance Commissioner's Hearings on Blue Cross-Blue Shield Rate Increase. In February, MSMS presented testimony to the Insurance Commissioner at both the Detroit and Grand Rapids hearings.

3. Co-sponsorship of Conference on Obesity. On March 14-15, in Detroit, MSMS and the Michigan Department of Health co-sponsored conferences on obesity and diabetes mellitus.

4. Upon invitation, MSMS appointed two physicians as advisors to the Michigan Crippled Children's Commission regarding revision of its fee schedule.

5. MSMS continues to have effective contact with other governmental agencies: Michigan Legislature, Michigan Department of Health, Office of Vocational Rehabilitation, Mental Health Department, State Board of Registration in Medicine and others.

6. MSMS had continuing contact with the Department of Social Welfare and the Governor's office regarding the Medical Aid to the Aged Program and the need for changing Rule 10 (see Annual Report of Legal Affairs Committee).

7. The Council's Liaison Committee with the State Executive Office made numerous recommendations to the Governor's office which were favorably received.

Contacts with Voluntary Organizations

1. Reports on the progress of Michigan Medical Service were made at Council meetings by MMS President Sidney Adler, M.D.

2. The Council increased its financial support of Michigan's two chapters of the Student American Medical Association.

3. MSMS appointed a representative to an Advisory Committee of the Michigan Congress of Parents and Teachers.

4. MSMS contributed to the Michigan School Health Association and increased its support of the U.S. Chamber of Commerce.

5. MSMS became a member of the Adult Education Association to increase its participation in education activities.

6. MSMS continued its important contact and liaison with other voluntary health groups, allied health professions and ancillary organizations.

7. Contact with Michigan Health Officers. In August, The Council entertained members of the Michigan Health Officers Association to improve liaison and cooperation.

8. Through its representatives, MSMS had continuing liaison with the Michigan Association of the Professions. This organization adopted resolutions opposing Social Security medical care and produced a weekly TV series which informed on various medical subjects.

9. Through the Michigan Health Council, MSMS has maintained contact with the Michigan Commission on Aging; the subject of Home Care was successfully promoted at its 1963 Annual Meeting.

Committees

A total of 103 meetings of Committees of The Council, of the House of Delegates, and of the Michigan State Medical Society, were held during the past year. In addition, 5 meetings were held of liaison committees to which MSMS sends official representatives.

The work of the various MSMS committees continues to serve as the foundation for effective service to our members and to the public.

The conscientious, dedicated efforts of the many committee members are essential, therefore, as MSMS meets its challenges. High praise must be accorded each committee chairman and committee member for self-sacrificing service.

See Annual Reports of Committees of The Council (pages 788-793) for reports of the following committees:

- Special Committee on Alcoholism and Drug Addiction
- Ad Hoc Committee on Oral Polio Vaccine
- Ad Hoc Committee on Study of Podiatry
- Ad Hoc Committee on Policies of The Council
- Committee on Courses on Medical Economics and Ethics
- Committee on Disaster Medical Care
- Committee on Medical Care Insurance
- Liaison Committee with Michigan State Board of Registration in Medicine
- Liaison Committee to Michigan State Nurses Association
- Committee on Recruitment of Superior Medical Students and the Need for Financial Aid
- Liaison Committee with Michigan State Pharmaceutical Association
- Committee on Rehabilitation
- Liaison Committee with State Bar of Michigan
- Liaison Committee with State Executive Office
- Committee on Veterans Affairs
- Committee to Study Problems of Indigent or Ill Physicians
- Centennial Committee
- Advisory Committee to Coordinator of 1965 Centennial
- MSMS Representatives to Joint Council to Improve Health Care of the Aged
- MSMS Representatives to Permanent Conference Committee
- MSMS Representatives to Liaison Committee with Michigan Society of Neurology and Psychiatry and the Michigan Psychological Society
- American Medical Association Education and Research Foundation

Legal Matters

Legal Counsel Lester P. Dodd has enjoyed a busy year. He attended all meetings of the House of Delegates and, except when prevented by illness, all Council meetings. As usual, he attended and participated in the MSMS Annual Session, the Michigan Clinical Institute, the Executive Secretaries Workshop and the Annual Seminar.

By reason of a very busy legislative year, Legal Counsel was required to and did spend more than the usual amount of time in participating in the

work of the Legal Affairs Committees. He also attended all meetings of and participated actively in the work of the House of Delegates Committee on Constitution and Bylaws and the Insurance Committee as well as participating, to the extent required, in the work and activities of many other committees.

During the year Mr. Dodd rendered approximately 50 written opinions and a larger number of informal opinions on a range of subjects coextensive with the activities of the Society and the interests of its members.

As usual, Mr. Dodd has counseled with and advised the officers and members of the staff in almost every facet of the Society's activities.

Medicare

Medicare is the national program whereby the dependents of military personnel are eligible to receive hospital and medical care from private physicians in the community where they reside. The program has served in preserving the private patient-physician relationship and has had the general support of the Michigan medical profession. Improvements could be attained in certain areas such as identification of dependents, the amount of paper work involved and in some of the listed fees. Effective June 1, 1963, the program was expanded to include the dependents of NATO forces stationed in or passing through the United States.

Veterans Administration Home Town Medical Care Program for Service-Connected Disabilities

The Veterans Administration on June 30, 1962, cancelled the use of an intermediary fiscal agent (Michigan Medical Service) in Michigan, one of the last states to have the use of an intermediary discontinued. The Home Town Medical Care Program for service-connected disabilities has continued uninterrupted, with the veterans authorized to receive medical care from their own physicians and the physicians receiving payment for services directly from the Veterans Administration. An ad hoc committee of The Council serves our membership in this program and has had assigned to it the renegotiation of fees.

1965 MSMS Centennial Celebration

The Council authorized development of plans for the MSMS Centennial Celebration in 1965. The site will be Detroit. Cobo Hall will be used for the Annual Session program and exhibits.

In conjunction with the Annual Session, a Michigan Health Fair is being arranged for Cobo Hall. A special arrangements committee will develop plans for this major undertaking.

Woman's Auxiliary

(By Mrs. Ross V. Taylor, Jackson, President)

I am pleased to submit the following brief report of the activities of the Woman's Auxiliary to the Michigan State Medical Society. A more detailed supplemental report will be in the Delegates' Handbook.

We launched our year's work in October with our District Meetings. The state committee chairmen as well as the state officers traveled around the state to these meetings. Every effort was made to inspire the local auxiliary officers and members and to promote auxiliary projects and programs.

In March, we held our Mid-Year Board Meeting in Detroit, attended by the county presidents and presidents-elect as well as state officers and chairmen. Guest speaker was Mrs. Frank Gastineau, the only woman member of the Board of the American Medical Political Action Committee. We were pleased to have Doctor A. B. Gwinn at our meeting to hear Mrs. Gastineau's presentation. At this meeting a resolution was passed offering the Auxiliary's aid to the Michigan State Medical Society in AMPAC activities.

In the field of legislation, "Operation Hometown" was launched in Michigan on May first.

During the past year, we have contributed $16,559.40 to AMA-ERF. This is an increase of $5,076.38 over the preceding year. Macomb County received a National County Achievement Award based on size of membership and contribution. They contributed $1,679.02 to AMA-ERF with 73 members.

International Health Activities, our newest project, has been well received. Large donations have been sent to World Medical Relief in Detroit. We were privileged to have its director, Mrs. Auberlin, speak to us at one of our state meetings.

In the field of Mental Health, much progress has been made in promoting the use of "Milestones to Maturity". Several loads of sample drugs were collected and sent to our state mental hospitals. Favorable legislation was promoted throughout the state.

Over 3,000 students participated in our TB and Respiratory Disease Speaking Project. This is a very important health education project. Many Auxiliaries place "Today's Health" in libraries and public places at auxiliary expense. Recruitment for Health Careers continues to be one of our major activities.

A $100 contribution was made to the Michigan Health Council and $300 was contributed to the Woman's Auxiliary to the Student AMA. We added a third Student Auxiliary Chapter in Michigan this last year—in Oakland County for the wives of interns and residents.

We have accomplished these things and much more with a membership of only half our potential. We could do so much more for American Medicine if all physicians' wives were members of the Woman's Auxiliary to the Michigan State Medical Society.

Public Relations

As the Michigan State Medical Society nears its 100th birthday it reviews its part in the profession's successful movement to improve the art and science of medicine. In the next two years the profession and the public will become more aware of this as the Society points with pride to its record.

However, the social environment in which medicine is practiced is changing. New economic and governmental forces are altering the patterns of living in our society. These alterations in the "organization" of society are inevitably affecting the location and methods whereby medical services are delivered, the personnel used to purvey them, and the manner in which payment for these services is made.

Also, in response to advances in medical science, new medical specialty organizations are arising. Today practically every segment of medical science has one or more societies devoted exclusively to it. In the minds of some of the doctors these specialty groups have replaced the AMA, MSMS and the county medical societies as the primary font of knowledge insofar as the practice of these specialties is concerned.

These rapid changes in the patterns of society and of the profession itself require MSMS and its component societies to re-examine the role they can play to serve best their members under the changing order.

It is not our purpose to survey herein that entire role but inevitably a far greater part of it in the future must be (1) the guiding of the medical profession's relationship with the general public, and particularly with "publics" whose concerns are chiefly in the health field, and (2) the coordinating of the intra-professional medical groups so that medicine presents a united front on policies that deal with the practice of medicine and the betterment of the public health, and (3) the establishment of maximum cooperation between other professions and the medical profession toward the end that the present attributes of professionalism as they have been so carefully evolved over the years are maintained.

It is toward these ends that the overall public relations efforts of MSMS have been directed. The more obvious evidences of these can be seen in the noteworthy report of public relations activities reviewed in the Annual Report of the Public Relations Committee. But MSMS recognized long ago that every member, every committee and every activity of the profession participates in creating the reputation of the profession.

Consequently, The Council has been concerned about the public relations impact of activities, events and happenings during the past year which have excited public interest. One of these was the great surge of interest in health evidenced, and contributed to, by the television programs featuring doctors, hospitals, nurses, etc., the outpouring of books about doctors, and the attention given to the profession's work by the news media. In these activities MSMS has cooperated well and the profession has been judged by competent analysts to have been advantaged.

A second has been the publicity accruing to the profession by virtue of its fight against the King-Anderson bill. In this regard MSMS has worked diligently and, again, has gained status with governmental policy heads.

The third has been the publicity emanating from the controversy between Blue Shield and the Michigan Commissioner of Insurance. To date public relations prudence has been exercised to minimize damage. It is recognized that this question is far from resolved and that, as it moves toward a solution, Medicine will have its opportunity to recoup any public relations losses occasioned by this unwanted conflict.

During the past year we have taken particular cognizance of several activities of public relations import. Among these are (1) The legislative effort including the Washington trip, the legislative conference dinners and the emergency aid station in the State Capitol; (2) The Get-Out-The-Vote campaign and support given towards the adoption of the new Michigan Constitution; (3) The outstanding work of both the Michigan Health Council and the Michigan Association of the Professions in their television program, "Decisions", plus the work of the former in the Home Care Program and the latter in its Congress of the Professions.

Medical Socio-Economics

The Council wishes to acknowledge the aid it has received from the Department of Medical Socio-Economics by way of data and recommendations which were of great value in making policy decisions.

The Medical Socio-Economic Committee has begun implementation of its study for long-range planning and this continuing study shall be most helpful to The Council and the House of Delegates.

The Research Director and Economic Consultant were of specific service to Councilors and officers on numerous occasions. For details on the activities of the Department, see the Annual Report of the Medical Socio-Economic Committee.

Legislation

The Michigan State Legislature, meeting in an extraordinarily brief session during 1963, considered a greater volume of proposed laws than the more lengthy 1962 assembly (over 1,500 bills and resolutions were introduced). Of these proposals, more than 50 required intensive study and action by the MSMS Legal Affairs Committee and staff.

A number of proposed new laws and amendments to existing laws which were endorsed and supported by MSMS were adopted by the 1963 Legislature. An even greater number of undesirable health proposals were properly rejected by the leg-

islators; no legislation not in the best health interests of the people of Michigan was enacted.

Frequently, MSMS members throughout the state were called upon to make available their expert opinion regarding health proposals to their State Senators and Representatives, and the splendid cooperation of physicians in this regard was primarily responsible for the resulting highly successful legislative session.

The Michigan Legislature enacted, for the first time, a "Good Samaritan Law" which exempts physicians from civil liability when rendering emergency care, unless in rendering the care they are guilty of "gross negligence or willful and wanton misconduct," A "Community Mental Health Services Law" was also enacted, in form endorsed by MSMS. A bill to safeguard the health of athletes by granting greater authority to ringside physicians, approved by MSMS, was also adopted.

In other critically important actions, the Legislature reorganized the administration of the total mental health program and, as endorsed by the Society, provided for a physician director of this important state activity. An MSMS-sponsored bill was also adopted to provide physicians with more time in which to bill the State for services rendered crippled and afflicted children, and to permit more realistic compensation to those physicians who perform multiple procedures.

The Professional Corporation Law, endorsed by MSMS and adopted in 1962, was further amended and improved during 1963. Legislation was passed which will make seat belts on private automobiles mandatory commencing in 1965.

The Legislature refused to pass a proposal which would have prohibited fluoridation of water unless approved by a plebiscite; it killed an anti-vivisection proposal in committee; it rejected proposals requiring a majority of "public representatives" on the Board of Blue Shield. The Legislature also refused to legalize the practice of psychotherapy by psychologists, and killed a proposal to grant power to the State Labor Department to conduct health inspections.

More than a dozen special study committees have been activated by the Legislature to consider and recommend legislation in health areas (chiropractic, podiatry, air pollution, community hospitals, etc.) and the MSMS Legal Affairs Committee and staff is maintaining close liaison with each study committee until it has completed its work by January, 1964.

In summary, through their effective assistance to lawmakers in evaluating proposals with medical implications, members of the Society have contributed in the highly successful legislative session of 1963. Furthermore, the Governor and legislators have demonstrated both rare understanding and willingness to respectfully weigh the educated views of doctors of medicine in scientific matters.

Michigan's New Constitution

The adoption of Michigan's new Constitution requires massive state government reorganization. At the direction of The Council, the Legal Affairs Committee is engaged in a long-term program of study and cooperation with official instrumentalities of government to assure that the eventual reorganization will serve the best health interests of the people of Michigan.

MSMS Headquarters

More and more committee meetings and conferences are being held at the East Lansing headquarters. The facilities are ideal for committee work and meal and travel costs are held to a minimum.

In addition, the building has served as a facility for improving liaison with related or ancillary organizations which have held board meetings in the headquarters, thus enhancing the public service image of MSMS.

The building is a beautiful structure and stands as a fitting symbol of the dignity and progressiveness of the Society. Members of the Society continue to receive favorable comments about the building from all who view it.

With the increased use of the building, more vigilance in maintaining the headquarters was required. The Building Advisor, Kenneth H. Johnson, M.D., has served as advisor to the staff on day-to-day problems and reports to The Council on improvements in operation.

It is the Building Advisor's responsibility to carry out the policies of The Council and act in its behalf in maintaining the building in top condition. The continuing maintenance program now in operation is designed to assure top appearance and the longest possible life for furnishings and equipment.

Matters Referred for Action by the 1962 House of Delegates

1. Substitute Resolution 2 directed that a second poll be taken of the total MSMS membership on the subject of physician inclusion in Social Security. This poll was taken in February, 1963, with the following results: "Do you favor inclusion of physicians under Social Security?" Yes, 3099; No, 1845; No Opinion, 20; Total returns, 4964. As instructed by the House, this information was transmitted to the AMA.

2. Resolution 66 directed that all physicians be reminded of their responsibility in reporting venereal disease. This action was reported to all members in the President's Letter of December 18, 1962.

3. Resolution 56 requested AMA to conduct or cause to be conducted a nationwide survey of the operation of the Kerr-Mills program with the objective of making any changes possible to improve its operation. This request was forwarded to C. Joseph Stetler, Director, AMA Legal and Socio-Economic Division, on October 24, 1962.

4. As a result of the recommendation of the

House of Delegates, a full-family life insurance program has been developed and offered to MSMS members. This improved coverage became effective February 1, 1963.

5. The $10 assessment for AMA-ERF was included with the 1963 dues billing. These funds are divided between Michigan's two medical schools for the aid of medical students on a per-student basis and will be presented to the two deans at the 1963 House of Delegates Annual Session.

6. The House authorized mailing of an annual report of MSMS to all members. This was accomplished on November 19, 1962.

7. In the November 1, 1962, Secretary's Letter, component societies were urged to assume leadership in youth fitness programs, implementing Resolution 7 of the 1962 House of Delegates.

8. Resolution 40 recommended that all hospital governing boards be requested to have at least one physician who is an active member of the medical staff as a regular voting member of the executive committee of the board. This resolution was transmitted to M.D. chiefs of staff and chairmen of boards of trustees of all medically-staffed hospitals in Michigan, on January 31, 1963.

9. As directed by Resolution 41, officers of component societies were requested on May 20, 1963, to submit nominations for appointment to MSMS committees.

10. To implement Resolution 45, letters were written to appropriate professional, collegiate, primary and secondary school officials in Michigan requesting that they study the development of a change in the type of helmet used by football players to provide greater safety.

11. Component societies were urged, in the November 1, 1962, Secretary's Letter, to promote Medical Self-Help Courses by appointing representatives to work with lay organizations interested in this activity. This was a recommendation of The Council approved by the 1962 House of Delegates.

12. Another recommendation, urging component societies to review their respective constitutions and bylaws and to revise them where needed to bring them into harmony with those of the State Society, and to transmit a copy to MSMS headquarters for review, was transmitted also in the November 1, 1962, Secretary's Letter.

13. As recommended by the House of Delegates, component societies were invited, in the County Societies Letter of April 28, 1963, to submit candidates to receive the MSMS Certificates of Commendation.

14. In the Secretary's Letter of November 1, 1962, component societies were requested to appoint county medical advisory boards to assist the Secretary of State in cases where drivers' licenses are suspended and a physical condition detrimental to driving may exist. This was done in accordance with action of the 1962 House of Delegates.

15. In the Secretary's Letter of November 1, 1962, component societies were urged to send delegations to Washington, D. C., as recommended by the House of Delegates. More component societies than ever before participated in this program.

16. Resolution 8, on Evaluation of Non-Hospital Medical Care, was referred by The Council to the Public Health Committee. The Public Health Committee studied possible means of evaluating the medical care of non-hospital patients, raised many questions on how such a study could be implemented, and concluded with the belief that implementation of such a project was not feasible. After additional consideration, this committee report was approved by The Council.

17. Resolution 16, concerning a definition of "single medical practice act," was referred by the House to The Council for further study and was referred by The Council to the Legal Affairs Committee. In view of the provisions of the new Michigan Constitution, an ad hoc subcommittee of the Legal Affairs Committee is working with Legal Counsel Lester P. Dodd to determine whether a "single medical practice act" is constitutional. A report will be made upon completion of the subcommittee's deliberations.

18. Resolution 19, dealing with the encroachment upon fields of medicine by public health services, was referred by The Council to the Public Health Committee for study. The Committee expressed the view that the function or role of state and local health departments described by the November 1962 AMA House of Delegates more adequately covers the functional role of state and local health departments than does the definition stated in the resolution. This report of the Public Health Committee was approved by The Council. (For details see Annual Report of the Committee on Public Health.)

19. Resolution 30 directed The Council to study the advisability of requesting suitable state legislation to enable the creation of health insurance pooling plans in this state. The Council referred this resolution to the Legal Affairs Committee. The pooling plan approach was invited to the attention of Governor George Romney. A subcommittee of the Legal Affairs Committee is continuing study of this matter and a report will be made upon completion of its deliberations.

20. Resolution 37 instructed the Committee on Professional Insurance to restudy the problem of providing continuing hospital coverage to the widows of MSMS members under the MSMS Blue Cross-Blue Shield contracts. Michigan Hospital Service and Michigan Medical Service informed the Committee that they are unable to comply with this request because they cannot make an exception for one group when they are not permitted to grant others this privilege.

21. Resolution 50 opposing Recommendation 20 of the Governor's Commission on Prepaid Hospital and Medical Care Plans, to establish an Advisory Council to the Insurance Commissioner, was re-

ferred to The Council. No such advisory committee has been appointed by Governor Romney.

22. Resolution 53 directed appointment of a special House of Delegates committee to study hospital emergency room care. Such a committee was appointed and has held several meetings. (See Annual Report of Committee to Study Emergency Care in Hospitals.)

23. Resolution 59 assigned to the Occupational Health Committee the task of analyzing the operation of the Unemployment and Workmen's Compensation Acts in Michigan and recommending such changes as will improve them in relation to health and sound philosophies of medical care. As a result of a detailed report by the Occupational Health Committee on this subject, The Council appointed a special committee in July, 1963, to work with the Chairman of the Section on Workmen's Compensation Laws of the State Bar of Michigan on this project; the study will continue.

24. Resolution 60 directed the establishment of a special study committee of The Council to investigate the merit of the proposal of the Michigan Constitutional Convention regarding consolidation of all agencies directly concerned with health care. The Council referred this matter to the Public Health Committee for study and report. In the interim the new Michigan Constitution was adopted and the Legal Affairs Committee was instructed to develop a plan for consolidating agencies under the terms of the new Constitution. A procedure has been adopted, meetings held with the State Health Commissioner and others. The consolidation must be completed by December, 1965.

25. Resolution 22 amended the Bylaws to provide that any or all of the duties assigned to the MSMS Secretary may be delegated by The Council to the Executive Director. This transfer of duties was made by The Council, to be effective January, 1964.

26. Resolution 61 recommended establishment of a study committee of MSMS, the State Bar and Governor's representative from the Secretary of State's office to develop legislation to improve detection, evaluation and reporting of newly acquired physical and emotional conditions which might impair ability to operate a motor vehicle. There have been no specific recommendations resulting from the discussions held so far.

27. Resolution 11, dealing with proposed detailed amendments to the Kerr-Mills Law and the Michigan Medical Aid to the Aged Act, was referred to the Medical Care Insurance Committee for careful study. The Council also referred this resolution to the Legal Affairs and Medical Socio-Economic Committees for study. Recommendations from the committees were received by The Council, awaiting further action by the Governor's office.

28. The question of doctors of osteopathy being participating doctors with MMS was referred to the special ad hoc committee dealing with overall MD-DO Relationship. Participation has been accomplished with the acceptance by Michigan Medical Service of the consent decree of Judge Theodore Bohn of Wayne County Circuit Court.

29. Resolution 1 supported the principle of partial government subsidy of privately administered prepaid medical care plans through income tax credit, or direct subsidy in the case of persons whose income is below taxable levels. This resolution was communicated to the American Medical Association and to Michigan Senators and Congressmen, as directed in the resolution.

30. Resolutions 5 and 36 dealt with legislation exempting physicians from civil liability when rendering emergency care. "Good Samaritan" legislation (Act No. 17, P.A. of 1963) was enacted by the Michigan Legislature in the 1963 session (see Legislative section of this report).

31. Resolution 10 reiterated opposition to mandatory reporting of positive serologies by laboratories and directed that any necessary legal or legislative steps be taken to place the responsibility for reporting of communicable diseases on the attending physician. Over the objections of The Council and other interested medical organizations throughout the state, the State Council of Health has upheld the ruling regarding mandatory reporting by laboratories of positive serology tests. This ruling is within the legal powers of the Health Commissioner and the Council of Health. MSMS Legal Affairs Committee has been requested to recommend what further action should be taken.

32. Resolution 14 urged enactment of laws for stricter physical examination of amateur and professional boxers, and granting additional authority to ringside physicians. This position of MSMS was given by letter to members of the Michigan Legislature. Subsequently legislation was introduced and enacted to bring about these changes. (Act No. 138, P.A. of 1963.)

33. Resolution 35 endorsed federal legislation designed to provide tax incentive for employers to include health care in employee retirement programs. A letter was sent by the State Society to Congressman Curtis thanking him for introducing this legislation. The Curtis Bill, embodying these ideas, has been adopted and signed into law.

34. Resolution 28 endorsed HB 39 of the 1962 Michigan Legislature, which provided for legislative review and approval of administrative rules promulgated by state agencies, and urged enactment of such legislation in 1963. A bill passed the House of Representatives, was opposed by Governor Romney and died in the State Senate. MSMS informed the Senate Judiciary Committee Chairman of the House of Delegates endorsement.

35. Resolution 42 directed that state legislation be sought to assure that administration of the Michigan Medical Aid to the Aged program be completely independent of the rules, regulations and policies of the Department of Social Welfare as applied to welfare cases, payments for all MAA

care to be the fair and average fee for services rendered. MSMS through its Legal Affairs Committee and legislative staff has persistently attempted to bring about a change in these administrative rules (see Legal Affairs Committee Annual Report).

36. Resolution 44, favoring recognition of general hospitals of size commensurate with needs in the case of small communities, and disapproving Recommendation No. 12 of the Governor's Commission on Prepaid Hospital and Medical Care Plans, was referred to The Council for implementation. All recommendations of this Commission are the subject of close scrutiny by the new Governor's office and MSMS has indicated its disapproval of several recommendations.

37. Resolution 46 directed introduction of legislation requiring that no less than two of the five members of the Michigan State Mental Health Commission be qualified psychiatrists. MSMS did support such legislation but subsequently the Legislature abolished the Mental Health Commission and instead appointed a Mental Health Advisory Council with the requirement that the Commissioner of Mental Health be a psychiatrist. MSMS also asked that the physicians appointed to the Council be in the same 2-5 ratio and nominations were made for these offices. The Advisory Council has not yet been appointed.

38. Resolution 4 directed that the Michigan Legislature be urged to request all tax-supported schools to furnish basic science courses for training students in nursing schools. This information was transmitted to the chairmen of the appropriate Senate and House committees. No legislative action was taken.

39. The following actions of the House were invited to the attention of Michigan Medical Service:

(a) Substitute Resolution 12, recommending payment by MMS of a surgical assistant's fee where such assistance is needed and actually rendered.

(b) Approval of Michigan Relative Value Scale as a basis for negotiating fee schedules with all governmental agencies, with the guideline that the fee schedule for the average income group is to be the basis for such negotiation, and referral of the RVS to the MMS Board of Trustees for implementation as soon as practicable.

(c) Request to MMS that it use the RVS in any and all contracts which MSMS is expected to implement on a service basis.

(d) Request to MMS that it readjust at least every three years the monetary unit value for the Relative Value Scale.

(e) Reaffirmation that MMS contracts for persons over 65 should reflect the community rating philosophy.

(f) Recommendation that, within the limitation that ⅔ of the MMS Board shall be physicians, public representation on the Board should be increased.

(g) Reaffirmation that payment for services by non-participating physicians should be made directly to the patient, unless the patient assigns the fee to the doctor.

(h) Resolution urging MMS to continue efforts to further enlarge the number of participating physicians.

Michigan Medical Service will report its study and/or action on these recommendations in its report to the House of Delegates or to the Membership of the Michigan Medical Service Corporation.

Recommendations of The Council

1. That The Council be authorized to arrange Councilor Conferences prior to the 1964 Annual Session and thus share pertinent information with the delegates, alternate delegates and component society officers, as during the past five years.

2. That the House of Delegates urge component societies to continue to hold "County-State Society Night programs" to provide officers and representatives of MSMS an opportunity to discuss mutual problems with component society members. A growing number of such meetings proved valuable during 1962-63.

3. That the House of Delegates again instruct that MSMS representatives be sent to Washington, D. C., in 1964 on "Michigan Day."

4. That the House of Delegates once again encourage more component societies to send delegations of members to Washington, D. C., to discuss legislative matters with their elected representatives.

5. That the House of Delegates participate actively in the forthcoming Centennial Celebration in 1965 and include in its considerations possible special observances by the House of Delegates.

6. That the House of Delegates highly endorse the AMA-MSMS campaign "Operation Hometown" and urge support and participation by all MSMS members.

THE COUNCIL
O. B. McGILLICUDDY, M.D., *Chairman*
H. H. HISCOCK, M.D., *Vice Chairman*
W. W. BABCOCK, M.D.
W. C. C. COLE, SR., M.D.
W. S. CARPENTER, M.D.
E. E. MARTMER, M.D.
D. W. McLEAN, M.D.
H. C. HANSEN, M.D.
W. A. SCOTT, M.D.
C. A. PAYNE, M.D.
J. J. COURY, M.D.
A. C. STANDER, M.D.
R. V. DAUGHARTY, M.D.
W. M. LEFEVRE, M.D.
J. R. DEHLIN, M.D.
D. R. SMITH, M.D.
B. M. HARRIS, M.D.
R. J. MASON, M.D.
C. I. OWEN, M.D., *President*
O. J. JOHNSON, M.D., *President-Elect*
J. J. LIGHTBODY, M.D., *Speaker*
J. W. RICE, M.D., *Vice Speaker*
OTTO K. ENGELKE, M.D., *Immediate Past President*
D. BRUCE WILEY, M.D., *Secretary*
W. A. HYLAND, M.D., *Treasurer*

Annual Reports of Committees of The Council

ANNUAL REPORT OF SPECIAL COMMITTEE ON ALCOHOLISM AND DRUG ADDICTION—1962-1963

The Committee met on two occasions in 1963 with an excellent attendance of the members. The first meeting was held at the Brighton Alcoholism Hospital and a tour of the facilities was made. The staff of Brighton Hospital explained their procedures for treating alcoholism and received questions and suggestions from members of the Committee. The second meeting was held at Edward W. Sparrow Hospital in Lansing for a similar review of the facilities available at the Alcoholism Center there. The principal work of the Committee throughout the year has been to collect nine papers on alcoholism to be presented in the October issue of the Michigan State Medical Society JOURNAL. Discussions of pending legislation regarding the misuse of paregoric have been held. A resolution was forwarded to the House of Delegates and passed favoring the devotion of more time to teaching about alcoholism in medical school curricula. Individual members of the Committee have participated in discussions with various county medical societies and it is felt that we are making significant progress in interesting physicians throughout the state in caring for alcoholics.

R. C. BATES, M.D., *Chairman*
T. S. CONOVER, M.D.
G. T. BRADLEY, M.D.
J. M. COOK, M.D.
D. L. DAMSTRA, M.D.
H. H. GAY, M.D.
G. F. MOENCH, M.D.
R. A. MOORE, M.D.
JACK ROM, M.D.
GUNNAR VETNE, M.D.
W. J. WERTZ, M.D.

ANNUAL REPORT OF AD HOC COMMITTEE ON ORAL POLIO VACCINE—1962-1963

During the past year, there have been no meetings of this Ad Hoc Committee on Oral Polio Vaccine since the actions taken in the previous year are still effective. At the present time we feel this Committee might be dissolved.

R. J. MASON, M.D., *Chairman*
E. E. MARTMER, M.D.
F. D. RICHARDS, M.D.
W. J. ZIMMERMAN, M.D.

ANNUAL REPORT OF AD HOC COMMITTEE ON STUDY OF PODIATRY—1962-1963

There have been no meetings of this committee during the past year as the impasse regarding what the podiatrists desire and could or should have has not been resolved. The podiatrists have not requested a meeting and it was felt that complacency on our part would be in order.

I would recommend that this committee be dissolved as it could always be re-activated should there be a request for it.

L. A. DROLETT, M.D., *Chairman*
W. H. BLODGETT, M.D.
B. M. HARRIS, M.D.
K. H. JOHNSON, M.D.
R. J. MASON, M.D.
H. J. MEIER, M.D.
G. THOMAS MCKEAN, M.D.

ANNUAL REPORT OF AD HOC COMMITTEE ON POLICIES OF THE COUNCIL—1962-1963

Since 1959, the policies and the more important actions of The Council have been extracted from the minutes of The Council and reprinted for quick and easy reference.

As the list grew, The Council felt that an indexing system was needed.

This Committee has reviewed the total material and has developed an indexing system for Council policies. The Committee recommends that new policies be incorporated in the mimeographed document published in November of each year following the annual reorganization of The Council.

The Committee further recommends that the publication of short-term decisions or actions (as opposed to long-range policy) be discontinued.

H. H. HISCOCK, M.D., *Chairman*
R. V. DAUGHARTY, M.D.
C. ALLEN PAYNE, M.D.

ANNUAL REPORT OF COMMITTEE ON COURSES ON MEDICAL ECONOMICS AND ETHICS—1962-1963

A most victorious year has been experienced. The courses on Medical Economics and Ethics were completed May 15, 1963.

Our Senior Medical Students, University of Michigan, have employed ingenious methods to secure attendance, as many of them had serious assignments in clinics and neighboring hospitals.

SCHEDULE OF LECTURES BEFORE U OF M SENIOR MEDICAL CLASS

1.	6/27/62	"DEVELOPMENT OF A FEE SCHEDULE," C. Howard Ross, M.D.
2.	7/11/62	"A HISTORY OF ETHICS," C. Howard Ross, M.D.
3.	7/18/62	"CONTINUING MEDICAL EDUCATION," John Tupper, M.D., Associate Dean
4.	7/25/62	"DUO PRACTICE IN THE EARLY YEARS," E. C. Pierce, M.D., and M. H. Hiraga, M.D.
5.	8/1/62	"THE DOCTOR IN COURT," Judge James R. Breakey, Jr. In this dissertation the Doctor is at the top of the totem pole.
6.	8/8/62	"AN ETHICAL APPROACH TO GERIATRICS," C. Howard Ross, M.D.
7.	8/15/62	"THE ETHICS AND ECONOMICS OF HOSPITAL ADMINISTRATION," Henry Morris, Associate Administrator, St. Joseph Mercy Hospital, Ann Arbor.
8.	9/ 5/62	"A DOCTOR WALKS AMONG MANY RELIGIONS," W. G. Fox, M.D. The Moslem, the Jew, the Catholic and the Protestant—may all be met in one morning's grand round.
9.	9/19/62	"THE SURGEON AND HIS FEE," Charles G. Child, M.D., Chairman Dept. of Surgery U of M Medical School.

10. 10/10/62 "HOW TO LAND IN COURT IN TEN EASY LESSONS," Lester P. Dodd, Attorney, Legal Counsel, MSMS. Here the Doctor may land at the bottom of the totem.
11. 10/17/62 "HOSPITAL AND INTERNSHIP DAY," Wm. Hubbard, M.D., Dean, Harry Towsley, M.D. 37 hospitals throughout Michigan sent representatives.
12. 10/31/62 "CLASS DAY, INSURANCE PROGRAM."
13. 11/ 7/62 "CLASS DAY, ESTATE PROGRAM."
14. 11/14/62 "MEDICAL MANPOWER," A. C. Furstenberg, M.D., Dean Emeritus. The Doctor in Michigan is balanced with needs of the present and prophecies of the future.
15. 12/12/62 "DOCTOR NORMAN MILLER DAY."
16. 1/ 2/63 "PROS AND CONS OF ACADEMIC MEDICINE," Robert Berry, M.D.
17. 1/16/63 "DOCTOR RICHARD SCHNEIDER DAY."
18. 1/23/63 "ORIENTATION WITH THE SPECIALTIES," GP Panel.
 (a) "INTRODUCTION," Moderator: C. Howard Ross, M.D.
 (b) "GENERAL PRACTICE AND THE SPECIALTIES," Howard Robinson, M.D.
 (c) "GENERAL PRACTICE IN A METROPOLITAN AREA," Lyle Korum, M.D.
 (d) "GENERAL PRACTICE WITH A RURAL SETTING," L. O. Shantz, M.D.
 (e) "CONSULTATION TECHNIQUES," E. Cochrane, M.D., and Douglas Haddock, M.D.
 (f) "ART OF THE PRACTICE," W. L. Rodgers, M.D.
 (g) "THE FAMILY PHYSICIAN'S PLACE IN THE COMMUNITY," Russell Fenton, M.D.
 (h) "GENERAL PRACTICE—THE KEYSTONE," A. C. Stander, M.D.
 (i) "MEDICAL ORGANIZATION," E. Clarkson Long, M.D.
19. 2/ 6/63 "HERE WE JOIN WITH THE ALPHA OMEGA ALPHA STUDENT FORUM."
20. 2/13/63 "STUDENT PLACEMENT IN MICHIGAN," Moderator: John Doherty. Participants: Lee Feldkamp, M.D., and C. Howard Ross, M.D.
21. 2/20/63 "MEDICAL COMMUNICATIONS AND PUBLIC RELATIONS," Mr. Hugh Brenneman and Wallace Teed, M.D.
22. 3/14/63 "WE JOINED WITH THE EDUCATIONAL FORUM FOR MEDICAL STUDENTS, INTERNS AND RESIDENTS, MCI DETROIT."
23. 4/ 3/63 "A DOCTOR'S PHILOSOPHY," C. Howard Ross, M.D.
24. 4/17/63 "SOCIOLOGICAL ASPECTS OF ETHICS," Wm. Hubbard, M.D., Dean, and George W. Morley, M.D., Dept. of OB-GYN, University of Michigan.
 (a) "RACE EXPLOSION."
 (b) "FAMILY PLANNING."
 (c) "RHYTHM TECHNICS VERSUS DIAPHRAGM AND OTHER MODALITIES."
 (d) "THERAPEUTIC ABORTION, CRIMINAL ABORTION."
 (e) "ARTIFICIAL INSEMINATION."
 (f) "HAS THE DECREASE IN THE INCIDENCE OF THERAPEUTIC ABORTION FOUND ITS ORIGIN IN SCIENCE OR MORALITY?"
 (g) "CATHOLIC HOSPITAL CODES, GENERAL HOSPITAL CODES."
 (h) "SURGICAL ATTACKS ON ORGANS OF PROCREATION MALE AND FEMALE, STERILIZATION."
 (i) "REMOVAL OF DISEASED ORGANS CONTAINING EMBRYO."
 (j) "SHOULD A CATHOLIC RESIDENT IN A GENERAL HOSPITAL DISMISS HIMSELF FROM AN OPERATION THAT SPECIFICALLY DOES NOT MEET HIS CODE?"
 (k) "DOCTOR AND NURSE RELATIONSHIPS IN PATIENT RESPONSIBILITY."
25. 5/ 1/63 "ORIENTATION COMMITTEE, WASHTENAW COUNTY MEDICAL SOCIETY," Joseph Fisher, M.D., and Winslow G. Fox, M.D. The Students posed as initiates in any county society of the United States.
26. 5/ 8/63 "THE DOCTOR'S ACCOUNTING SYSTEM," Robert Danauer.
27. 5/15/63 "COMBINED MEETING WITH THE SENIOR MEDICAL CLASS AND THE AMERICAN MEDICAL WRITERS' ASSOCIATION, MICHIGAN CHAPTER."
 (a) "WORKSHOP." I.
 1. "PAPER PLANNING," C. Howard Ross, M.D.
 2. "RESEARCH, SURGERY AND REPORTING," Clarence Crook, M.D.
 3. "ENGLISH USAGE," Ruth Good.
 4. "TRANSLATING SCIENTIFIC FINDINGS TO THE LEVEL OF LAY CONSUMPTION," Richard Emmons.
 (b) "WORKSHOP." II.
 1. "EDITING RESEARCH PAPERS," Russell DeJong, M.D.
 2. "SPIRIT OF THE PAPER," Charles Sellers, M.D.
 3. "KEEP IT SIMPLE," Hazen Miller, M.D.
 4. "HISTORICAL PAPERS," Alfred Whittaker, M.D.
 (c) LUNCHEON PROGRAM "EDUCATIONAL VALUE IN MEDICAL WRITING," Wm. Hubbard, M.D., Dean, U of M Medical School.
 (d) "PANEL: STUDENT PAPERS," Moderator: Wilfrid Haughey, M.D., Editor JMSMS.
 1. "PRINCIPLES OF INTESTINAL ABSORPTION," Fred Wright.
 2. "AN HISTORICAL APPROACH TO HYPNOSIS," Kurt Wuepper.
 3. "DISCUSSION," By Drs. Kahn, Dorsey and Ross.
 (e) "RECEPTION HOUR."

As in previous years notes were taken by the generous students present for absentees, and secondary sessions occurred in dormitories and fraternities.

Our gratitude is expressed for the brilliant contributions of visiting speakers, members of the committee and the Senior Medical Class.

The annual meeting of our committee will occur the third Sunday (18th) in August, 1963. This will be associated with the annual class breakfast for the Senior Medical Students and wives, plus certain high school selectees. We will celebrate at my home, 180 Underdown Road, Barton Hills, Ann Arbor, Michigan, at 10:30 A.M. All members of the committee and their wives are urged to attend. After the breakfast festivities have passed, we will retire to the Barton Hills Country Club for the executive session, inviting medical class officers to join us. Dinner follows.

Kindly process the above date and let me know if it passes muster.

Any further information required will be gladly furnished.

C. Howard Ross, M.D., *Chairman*
H. A. Towsley, M.D.
G. D. Albers, M.D.
R. E. L. Berry, M.D.
W. S. Carpenter, M.D.
G. O. Clifford, Jr., M.D.
W. N. Hubbard, Jr., M.D.
C. W. Royer, M.D.
H. J. Schmidt, M.D.
G. H. Scott, Ph.D.
J. M. Sheldon, M.D.
R. W. Teed, M.D.
S. B. Winslow, M.D.
J. A. Witter, M.D.

ANNUAL REPORT OF COMMITTEE ON DISASTER MEDICAL CARE—1962-1963

For the past several years the Michigan State Medical Society has cooperated with the Michigan Office of Civil Defense in the planning for Disaster Medical Care. The Committee, under Doctor C. P. Anderson, offered continued cooperation with the Michigan State Police who assumed the responsibility of Civil Defense activities for the State of Michigan on August 1, 1962.

In the past year, the Committee recognized the need for the implementation of a regional civil defense plan for the state, and recommended that the planning be reviewed with representatives of the State Department of Health. The Committee also met with representatives of the Governor's Task

Force on Emergency Planning to discuss other needs such as manpower, transportation, etc.

Other activities included assisting in the initiation of the development of an operational manual for the Civil Defense Emergency Hospital, obtaining the cooperation of the Michigan State Pharmaceutical Association, to collect data on essential medical supplies that are located throughout the State, endorsing a proposed FM Medical Radio network with the possibility of adaption to disaster medical care, urging individual members of the Medical Society to familiarize themselves with county disaster medical plans, and reemphasizing the need for Medical Self Help Training for the families of Michigan.

C. P. Anderson, M.D., *Chairman*
G. L. Otis, M.D., *Vice Chairman*
T. I. Boileau, M.D.
D. H. Fryer, M.D.
J. R. Dehlin, M.D.
R. F. Hague, M.D.
M. L. Lichter, M.D.
J. D. Miller, M.D.
W. B. Prothro, M.D.
S. R. Russell, M.D.
C. J. Sprunk, M.D.
M. E. Wehner, M.D.
E. F. Wolfman, Jr., M.D.
W. W. Armistead, DVM, *Advisor*
Mr. Jacques Cousin, *Advisor*
Mr. Robert C. Johnson, *Advisor*
Mrs. Marie Rodriguez, R.N., *Advisor*
D. D. Smith, D.D.S., *Advisor*

ANNUAL REPORT OF COMMITTEE ON MEDICAL CARE INSURANCE—1962-1963

The Committee has studied and made recommendations on the Medical Aid for the Aged Legislation in Michigan, which is the implementation of the Kerr-Mills Bill. Beginning in March of 1963 The Council approved an evaluation of Michigan State Medical Society and Michigan Medical Service relationships. Meetings have been held and are scheduled with management, with subscribers, with members of the Board of Directors of MMS, and with other interested persons. A supplemental report will be given to The Council before the meeting of the House of Delegates in September of 1963.

J. W. Rice, M.D., *Chairman*
M. L. Lichter, M.D., *Vice Chairman*
J. D. Fryfogle, M.D.
L. F. Hayes, M.D.
J. D. Littig, M.D.
E. E. Martmer, M.D.
R. L. Mainwaring, M.D.
W. F. Strong, M.D.
A. R. VandenBerg, M.D.

ANNUAL REPORT OF LIAISON COMMITTEE WITH MICHIGAN STATE BOARD OF REGISTRATION IN MEDICINE—1962-1963

This Committee met with members of the State Board on Friday, March 15, 1963, at the Sheraton-Cadillac Hotel in Detroit, Michigan.

The Michigan Medical Practice Act was discussed. Doctor Swanson reported that investigations are on the increase and additional personnel are needed. Doctor Swanson requested support for his program and budget. Doctor Engelke suggested that such support would be considered if program reports and budget information were available to the MSMS sufficiently in advance. Doctor Swanson agreed to send his program and budget to MSMS in advance of next year's schedule.

Closer working relationships between the Board and county medical societies were discussed. Doctor Swanson distributed diagrams illustrating the workings of the Medical Practice Act, and an educational program to acquaint MSMS members with the Act was also discussed.

The question of accreditation of osteopaths who were granted M.D. degrees by the California College of Medicine was raised. The State Board said it was recognizing those who graduated from the California College of Medicine, who had completed the fourth year class and graduated in June of 1962, as graduates of an accredited medical school. Graduates of that institution prior to February 15, 1962, are not to be so recognized even though qualified as M.D.s in California.

Otto K. Engelke, M.D., *Chairman*
K. H. Johnson, M.D.
O. J. Johnson, M.D.
C. I. Owen, M.D.

ANNUAL REPORT OF LIAISON COMMITTEE TO MICHIGAN STATE NURSES ASSOCIATION—1962-1963

Discussions were held on several subjects concerning the inter-relationship between doctors and nurses. This included such things as professional care and treatment of nurses, the objectives of the AMA committee on nursing and also current problems. The attendance was good.

E. M. Vardon, M.D., *Chairman*
J. D. Miller, M.D.
H. M. Fuller, M.D.
H. H. Hiscock, M.D.
E. G. Merritt, M.D.
J. A. Witter, M.D.

ANNUAL REPORT OF THE COMMITTEE ON RECRUITMENT OF SUPERIOR MEDICAL STUDENTS AND THE NEED FOR FINANCIAL AID—1962-1963

The Committee on Recruitment of Superior Medical Students and the Need for Financial Aid has held no meetings during the past year.

Your Chairman has had conversations on several occasions with representatives of S.A.M.A., and, to date, the students are not aware of any degree of effectiveness of the program. It is my understanding that the moneys assessed by the state were only recently turned into the AMA-ERF offices, and that perhaps within the next year shall begin to notice the effect of the generous contribution made by the doctors of Michigan to this national program.

The Committee intends to incorporate reports from the deans of the two schools in the following

year more or less detailing the practical results of the Michigan contribution to this program.

Glenn E. Millard, M.D., *Chairman*
J. M. Sheldon, M.D., *Vice Chairman*
A. B. Gwinn, M.D.
H. C. Hansen, M.D.
N. D. Henderson, M.D.
G. E. Moore, M.D.
Morton Levitt, Ph.D., *Advisor*
C. J. Tupper, M.D., *Advisor*

ANNUAL REPORT OF LIAISON COMMITTEE WITH THE MICHIGAN STATE PHARMACEUTICAL ASSOCIATION—1962-1963

The Committee met on May 1, 1963. A suggested interprofessional code of understanding between physicians and pharmacists was received for information, further study and future recommendations.

Drug vending machines were discussed and resulted in the passage of the following motion. "The Drug Vending Machine *may* have its place in our present system of distribution. We hold however, that if this device is applied to the distribution of prescription drugs, proper overall controls by a pharmacist should exist."

Sections 17 and 28 of the new Pharmacy Law (1963) relate specifically to physicians. Your attention is respectfully called to the review article on page 83 of the January 1963 issue of The Journal of the Michigan State Medical Society written by Mr. Robert C. Johnson, Executive Secretary of the Pharmaceutical Association.

The recommendation that liaison committees be established on a county level was reiterated.

R. H. Trimby, M.D., *Chairman*
B. P. Brown, M.D.
H. H. Hiscock, M.D.

ANNUAL REPORT OF COMMITTEE ON REHABILITATION—1962-1963

This Committee believes that one of the most important services it can perform for the benefit of practicing physicians in Michigan is to survey existing rehabilitation facilities and services in each area of the state.

Much data exists, but no comprehensive collection of facts is available to facilitate and encourage the greater use of rehabilitation facilities and services by MSMS members.

In May, The Council approved this Committee's plan to collect all pertinent rehabilitation data. It is estimated that the comprehensive study will require about six months to complete once the questionnaire is in final form. We expect the study to be underway by September, 1963, with the cooperation of component society rehabilitation chairmen and the Division of Vocational Rehabilitation.

Each member of the MSMS Rehabilitation Committee will serve as study coordinator in his respective geographical area.

This undertaking will require much time and effort on the part of all involved, but your Committee believes that the importance and lasting value of the project more than justify the personal expenditure.

S. D. Steiner, M.D., *Chairman*
R. W. Pomeroy, M.D., *Vice Chairman*
G. T. Aitken, M.D.
R. H. Allen, M.D.
H. M. Andre, M.D.
M. F. Bruton, M.D.
R. L. Fitts, M.D.
J. H. Ganshow, M.D.
H. C. Hansen, M.D.
C. M. Hanson, M.D.
Mana Kessler, M.D.
A. C. McClay, M.D.
J. W. Rae, Jr., M.D.
J. N. Schaeffer, M.D.
J. M. Schwartz, M.D.
O. D. Stryker, M.D.

ANNUAL REPORT OF LIAISON COMMITTEE WITH STATE BAR OF MICHIGAN—1962-1963

The Committee met with representatives of the State Bar of Michigan and the Michigan Hospital Association and approved a Statement of Principles for hospitals, lawyers and doctors.

The final meeting was held on April 17, 1963. The Statement has been approved by committees of all three organizations. The Liaison Committee has recommended approval by the parent associations. Thus far, only The Council of MSMS has approved the Statement (on May 15, 1963).

Wm. M. LeFevre, M.D., *Chairman*
F. B. MacMillan, M.D., *Vice Chairman*
Mr. Lester P. Dodd
A. A. Humphrey, M.D.
D. M. LeDuc, M.D.

ANNUAL REPORT OF LIAISON COMMITTEE WITH STATE EXECUTIVE OFFICE—1962-1963

This Committee has functioned under the specific direction of The Council. It has held six meetings, five of which have had to do with areas of common interest between MSMS and the functioning of the various Boards and Committees of State Government. The other meeting was held to evaluate the problems arising as a result of the disagreement between the Commissioner of Insurance and Blue Shield. A report to The Council has been made in each instance.

K. H. Johnson, M.D., *Chairman*
B. M. Harris, M.D., *Vice Chairman*
Otto K. Engelke, M.D.
O. J. Johnson, M.D.
L. R. Leader, M.D.
J. J. Lightbody, M.D.
O. B. McGillicuddy, M.D.
C. I. Owen, M.D.
D. Bruce Wiley, M.D.
Mr. Wm. Burns, *Advisor*
Mr. Hugh W. Brenneman, *Advisor*

ANNUAL REPORT OF COMMITTEE ON VETERANS' AFFAIRS—1962-1963

This Committee has undergone change in function over the years. Initially it developed close and cordial liaison with the four major veterans service

organizations at the level of the respective chief service officers. When the Veterans Administration cancelled the use of intermediary (Michigan Medical Service) for the Home Town Care Program for Service Connected Veterans, the responsibility for negotiating new fee schedules for this category was assigned to this Committee, and its name changed to the present one. In this increased assignment no Committee meeting has been held to date, but dossier is being developed.

William Bromme, M.D., *Chairman*
L. C. Carpenter, M.D.
J. E. Croushore, M.D.
W. S. Jones, M.D.
H. J. Kullman, M.D.
W. A. Scott, M.D.
G. W. Slagle, M.D.
D. Bruce Wiley, M.D.
Mr. Sumner G. Whittier, *Advisor*

ANNUAL REPORT OF COMMITTEE TO STUDY PROBLEMS OF THE INDIGENT OR ILL PHYSICIAN—1962-1963

No cases were referred to this committee during the past year; therefore, no meetings were held.

R. J. Fles, M.D., *Chairman*
W. L. Brosius, M.D.
B. P. Brown, M.D.
J. L. Leach, M.D.
E. M. Vardon, M.D.
A. H. Whittaker, M.D.

ANNUAL REPORT OF THE CENTENNIAL COMMITTEE—1962-1963

The Centennial Committee, composed of Past Presidents of the Michigan State Medical Society, met on September 27, 1963, with Otto K. Engelke, M.D., as Chairman.

The Committee recommendations were as follows:

1. That The Council consider undertaking a combined 1965 Annual Session and a Health Fair (with public participation in the latter, in Cobo Hall, Detroit).
2. Begin in the September 1964 JMSMS the first of a series of articles on the history of MSMS by Historian Wm. J. Stapleton, Jr., M.D. (the articles to include Beaumont).
3. Encourage a large scientific exhibit on the occasion of the Centennial and Health Fair, including displays from non-medical scientific bodies such as government, Michigan Bell (Telstar), etc.
4. Urge all ancillary, scientific and medical groups of Michigan—well in advance of the Centennial—to hold meetings coincident with the 1965 session in Detroit.
5. Develop some special recognition for all living Past Presidents (such as a special dinner of the House of Delegates to which the Past Presidents would be invited as honored guests).
6. Urge the AMA to hold its AMA Institute in Detroit, immediately before, during, or the week after the Centennial.
7. Urge the National Association of Blue Shield Plans to meet in Detroit the week before, during, or the week after the MSMS Centennial.
8. Urge the postal department to authorize a commemorative cancellation of postage stamps, indicating the Centennial of MSMS, on all cancelled stamps in Michigan.

This Committee considered a recommendation that the name of the Michigan State Medical Society be changed to the "Michigan Medical Association" in line with the modern names of other state medical societies. No action was taken on this at this time, and it was requested that a report of the name changes of other state medical associations be sent to each member of the Committee. It was proposed that the name change, if recommended, should take place in 1965, the MSMS Centennial Year.

The Beaumont Memorial Foundation indicated that it would be happy to loan the dioramas and displays presently in the Beaumont Memorial on Mackinac Island for use during the 1965 Centennial.

The Centennial Committee reviewed some 26 suggestions for the 1965 Centennial and these were sent as information to The Council. The Committee felt that The Council must adopt centennial policy and stated that it felt its function was advisory to The Council and that the actual implementation of Council policies should be done by other working committees and staff.

The Committee is enthusiastic about the 1965 Centennial celebration and hopes that The Council will soon appoint a Chairman of Arrangements for the Centennial and a Chairman of Arrangements for the Health Fair so that these chairmen and their working committees can begin considering the preliminary suggestions and recommendations made by this Committee and others.

Otto K. Engelke, M.D., *Chairman*
Milton A. Darling, M.D.
R. J. Hubbell, M.D.
L. W. Hull, M.D.
K. H. Johnson, M.D.
W. S. Jones, M.D.
G. B. Saltonstall, M.D.
G. W. Slagle, M.D.
C. I. Owen, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE TO COORDINATOR OF CENTENNIAL—1962-1963

This Committee was created to advise on preliminary plans for the Centennial celebration in 1965, until a specific Centennial Arrangements Committee is appointed.

The Committee reviewed an extensive list of possible plans for the Centennial celebration and reviewed suggestions for a health fair or exposition to be held concurrently with the 1965 Annual Session.

The Committee recommended that a health fair or exposition be held in 1965 on a free admission basis and that Legal Counsel be authorized to proceed with incorporation of the "Michigan Health Fair, Incorporated."

The Council approved this recommendation.

In July of 1963, the functions of this Committee will be assumed by the Centennial Arrangements Committee.

W. W. Babcock, M.D., *Chairman*
E. E. Martmer, M.D.
R. J. Mason, M.D.
O. B. McGillicuddy, M.D., *ex officio*

ANNUAL REPORT OF MSMS REPRESENTATIVES TO JOINT COUNCIL TO IMPROVE THE HEALTH CARE OF THE AGED—1962-1963

The Committee met once in Lansing and discussed several important projects. The new Program of Dental Care in Nursing Homes and Homes for the Aged was particularly gratifying. Surveys conducted by the Department of Health, State Dental Society and the University of Detroit Dental School revealed a great need for dental care and recommended certain remedial measures.

The Joint Council activities in the Muskegon area were reported and point up dramatically what can be accomplished with good leadership. It is hoped added study and projects will be developed in other State areas.

A six-week training course for Nursing Home Administrators and Personnel was held in Lansing this summer as a pilot project by the Michigan State University. This course was developed at the request of the National Department of Health. Education and Welfare and it is hoped it will be given elsewhere. Some of our members participated in the program.

A. Hazen Price, M.D.
F. C. Swartz, M.D.
S. C. Wiersma, M.D.

ANNUAL REPORT OF MSMS REPRESENTATIVES TO PERMANENT CONFERENCE COMMITTEE—1962-1963

This group this year reviewed the statement of purpose and organization of the Permanent Conference Committee for the enlightenment of the newer representatives from the different groups. The value of continuing some of the same members from each group on the committee was stressed so that each group would be cognizant of the purpose and procedure of the Permanent Conference Committee. Several areas of common concern were discussed. The value of such a combined committee was again stressed.

E. M. Vardon, M.D., *Chairman*
J. D. Miller, M.D., *Vice Chairman*
H. M. Fuller, M.D.
H. H. Hiscock, M.D.
E. G. Merritt, M.D.
J. A. Witter, M.D.

ANNUAL REPORT OF MSMS REPRESENTATIVES TO LIAISON COMMITTEE WITH MICHIGAN SOCIETY OF NEUROLOGY AND PSYCHIATRY AND MICHIGAN PSYCHOLOGICAL SOCIETY—1962-1963

No matters were brought to the attention of this Committee during the past year so that it was unnecessary to call the Committee into session.

Z. S. Bohn, M.D., *Chairman*
Marion Chaskes, M.D., *Vice Chairman*
G. H. Reye, M.D.
W. A. Scott, M.D.
R. W. Waggoner, M.D.

ANNUAL REPORT OF AMERICAN MEDICAL ASSOCIATION EDUCATION AND RESEARCH FOUNDATION—1962-1963

Interest in AMA-ERF was increased and more productive in 1962. The $10.00 assessment for this purpose passed by the 1962 House of Delegates will be reflected in the 1963 report. The May 4 issue of *The Journal AMA* reports Physicians and Physician Related Contribution from Michigan in 1962 was $46,843.47. The energies of the Committee of the Woman's Auxiliary, Mrs. William G. Gamble, Jr., of Bay City, Chairman, resulted in about a 30 per cent increase from this organization.

Checks of $21,000 and $14,000 were presented to the University of Michigan and Wayne State Medical Schools, respectively, in March of 1963.

The loan and research phases of the new AMA-ERF seem to have made it more attractive to donors. The program of the headquarters in Chicago have been of great aid in activities for the Fund.

O. J. Johnson, M.D., *Chairman*

Annual Reports of MSMS Committees

ANNUAL REPORT OF COMMITTEE ON CARDIAC DISEASE CONTROL—1962-1963

The Cardiac Disease Control Committee met on February 13, 1963, but its work continued throughout the year.

Financial support for the Rheumatic Fever Control Program was secured from the Michigan Heart Association with additional funds to support the Program into 1963.

A policy of liaison with the Michigan Heart Association was agreed upon, and the Committee reiterated its aim "to aid the physician to better care for his patients."

The revision of the desk reference cards on Rheumatic Fever continues and should be ready for distribution before the next expected seasonal outbreak. Similar cards on the subjects of Coronary Artery Disease, Stroke Rehabilitation, as well as Congenital Heart Disease, are also being prepared.

This Committee plans to meet with an appropriate committee of the Michigan Heart Association, the State Health Department, the Crippled Children Commission, the Department of Vocational Rehabilitation, and other agencies whose interest involves cardiac disease control and treatment.

Resolution No. 33 from the 1962 House of Delegates, re: Hospital Staff Meeting Speakers, etc., was referred to a subcommittee for re-introduction at the 1963 meeting of the House of Delegates.

A poll of the county medical societies fails to reveal any intense interest in rheumatic fever or congenital heart disease diagnostic clinics. The county societies did express an interest in speakers on heart disease, and these requests were referred to the Michigan Heart Association for implementation.

The Committee thanks the MSMS staff for its efficient assistance throughout the year.

Sidney E. Chapin, M.D., *Chairman*
J. G. Bielawski, M.D.
F. J. Chapin, M.D.
Leon DeVel, M.D.
S. T. Harris, M.D.
M. S. Hecht, M.D.
F. D. Johnson, M.D.
T. B. Mackie, M.D.
W. D. Robinson, M.D.
G. W. Slagle, M.D.
E. J. Tallant, M.D.
Mr. Abraham Brickner, *Advisor*
J. A. Cowan, M.D., *Advisor*
Mr. James Gerity, Jr., *Advisor*

ANNUAL REPORT OF COMMITTEE ON CHILD WELFARE—1962-1963

The Committee held one meeting, May 8, 1963, and endorsed a training course for Camp Health Directors, as a possible method of providing approved health supervision for children attending summer camps.

The Subcommittee on School Health Problems met with representatives of the State High School Athletic Association and discussed criteria for weight control of students involved in High School wrestling activities.

The Subcommittee on Ophthalmology continues its activities in cooperation with the Michigan Department of Health with the Sight Testing program, and with the Michigan Crippled Children Commission in its prevention of blindness program and providing, where necessary, contact lenses or glasses for children under the Michigan Crippled Children program. It was reported that in Michigan there are about 500,000 children who are under an approved screening program during a school year, and that this amounts to about 44.6 per cent of the school age children of the state.

The Committee continued its endorsement of the Youth Fitness Program, with special regard to the total health of the youth, rather than just physical health, recommending good nutrition and good mental health, as well as adequate exercise.

The Committee also suggested a possible study by the University of Michigan School of Public Health, with regard to the level of immunization of Michigan children and the availability of various vaccines within the state.

R. H. Trimby, M.D., *Chairman*
F. J. Margolis, M.D., *Vice Chairman*
R. T. Blackhurst, M.D.
C. E. Booher, M.D.
D. A. Campbell, M.D.
E. L. Cooper, M.D.
G. B. Corneliuson, M.D.
J. E. Coyle, M.D.
E. H. Crawley, M.D.
E. R. Elzinga, M.D.
R. M. Heavenrich, M.D.
C. G. Jennings, M.D.
S. N. Kelso, Jr., M.D.
J. P. Klein, M.D.
P. J. Laux, Jr., M.D.
O. L. Lepard, M.D.
Don Marshall, M.D.
Joanne E. Mertz, M.D.
J. C. Montgomery, M.D.
C. F. Payton, M.D.
H. A. Towsley, M.D.
A. L. Tuuri, M.D.
R. J. Mason, M.D., *Advisor*

ANNUAL REPORT OF COMMITTEE ON DIABETES—1962-1963

During the detection campaign of November, 1962, conducted by the Michigan Diabetes Association and the Diabetes Committee of the Michigan State Medical Society, there were a total of 17,889 persons screened for diabetes in Michigan. One

thousand, one hundred nineteen of these were shown to be positive at the first test. After rechecking these 1,119, 276 cases of diabetes were discovered, a yield of 1.5 per cent.

This program was not as extensive as it will be in future years. The action of the State Medical Society in deciding to cooperate with the Michigan Diabetes Association and the State Health Department in the more extensive use of the clinitron in the screening program will greatly increase the areas of screening in the future.

Your committee is still actively cooperating with its allied organization in planning these future campaigns.

Wm. M. LeFevre, M.D., *Chairman*
F. W. Whitehouse, M.D., *Vice Chairman*
Sidney Adler, M.D.
W. L. Anderson, M.D.
J. A. Cowan, M.D.
R. F. Fenton, M.D.
E. W. Fitzgerald, Jr., M.D.
T. B. Mackie, M.D.
F. S. Perkin, M.D.
J. B. Rowe, M.D.
L. F. Segar, M.D.
K. K. Vining, Jr., M.D.
H. L. Woodburne, M.D.

ANNUAL REPORT OF COMMITTEE ON ETHICS—1962-1963

Only one problem presented itself and that consisted of one county society asking "what other county societies have done in cases where members may have been convicted of falsification of income tax returns with intent to defraud. In the particular case in question the doctor had been sentenced to a heavy fine and a period of probation by the government."

It was almost the unanimous opinion of the Ethics Committee all of whom were contacted that it was really none of our business inasmuch as he had already been punished and the lesson he was taught should have sufficed, with no later repercussions.

So, once more, we have a well behaved society adding another year to a series of sensible actions from an ethical standpoint.

H. W. Porter, M.D., *Chairman*
F. M. Doyle, M.D.
W. L. Harrigan, M.D.
F. H. Lindenfeld, M.D.
J. D. Miller, M.D.
George Mogill, M.D.
E. A. Osius, M.D.
A. Hazen Price, M.D.

ANNUAL REPORT OF COMMITTEE ON GERIATRICS—1962-1963

The Geriatrics Committee was responsible for the May issue of the Michigan State Medical Society Journal. This year it was made up of a series of articles having to do with the Institutional Care of the Aged and was planned by a sub-committee composed of Doctors Rom, Getting and Sellers.

The various facilities responsible for this type of care were described by persons very knowledgable in their respective fields. In addition, the improved methods of licensure were presented, as well as methods of financing construction through the Hill-Burton Program. Particular emphasis was upon the Geriatric patient in the State Mental Hospitals, as well as those in County and General Hospitals.

Patient care in Nursing Homes and Homes for the Aged with the recently added dental care was given special consideration. It is hoped we may again have the privilege of formulating another issue.

In the coming year we hope to give added consideration to the problems of retirement and their effect upon the health of the older person. Additional effort will be made to initiate a program examination of all recipients of old age relief as a prophylactic measure against long term illness. A closer cooperation with the Commission on Aging is hoped for since Doctor Hirschfeld, a member of our Committee, was appointed to the Commission.

Our Committee met two times, once in Saginaw and once in Detroit. During the Michigan Clinical Institute a Sub-committee, headed by Doctor Gittins, arranged for a Public Forum which was well attended considering the weather. Some of our Committee participated in the presentation of the general subject, "Some Problems of the Aging American."

Several members of the Committee attended the Annual Ann Arbor Conference on Aging held during June, 1963. The subject, "Aging and Social Policy," was of particular interest to physicians.

A. Hazen Price, M.D., *Chairman*
F. C. Swartz, M.D., *Vice Chairman*
H. B. Bennett, M.D.
J. R. Brink, M.D.
J. W. Clay, M.D.
G. S. Fisher, M.D.
R. L. Fitts, M.D.
J. V. Fopeano, M.D.
V. A. Getting, M.D.
P. C. Gittins, M.D.
A. H. Hirschfeld, M.D.
W. W. Kitti, M.D.
Jack Rom, M.D.
Herbert Rosenbaum, M.D.
C. Howard Ross, M.D.
L. F. Segar, M.D.
C. W. Sellers, M.D.
C. K. Stroup, M.D.
V. K. Volk, M.D.
S. C. Wiersma, M.D.

ANNUAL REPORT OF COMMITTEE ON HIGHWAY ACCIDENT PREVENTION—1962-1963

One meeting of the Committee was held this year. The Executive Secretary of the Michigan State Safety Commission and the Chief of the Driver Improvement Program of the Michigan Department of State were guests, and mutual problems were discussed.

A representative of a major seat-belt manufac-

turing company offered to sell seat belts to members of the MSMS at wholesale prices, and this offer was accepted with such action not to be construed as endorsement of any particular make of seat belt. All members of MSMS have received this advertising material.

The Committee made itself available to the members of the interim legislative committee on traffic safety of the State Senate, and copies of the AMA chemical test manual were distributed to the members of the Senate committee.

The Committee recommended that MSMS communicate with Michigan police chiefs and sheriffs, informing them that it is the considered viewpoint of Medicine that the Snellen Chart is the preferred tool for driver vision testing by lay personnel, and that in such hands the use of visual screening instruments may be inferior.

The Committee recommended that MSMS reiterate its support for the passage by the State Legislature of the Uniform Vehicle Code provisions for the testing of intoxicated drivers if such a proposal is introduced during the 1963 session.

The Committee notes with enthusiastic approval the passage by the recent Legislature of legislation making mandatory the providing of seat belts on all cars sold after January 1, 1965, and wishes to thank all members of MSMS who over the years have helped to awaken public interest in seat belts.

The members of the Committee were active in matters of traffic safety in their own County Medical Societies and local communities. Numerous safety problems were discussed in the meeting of the Committee on which no official action was taken.

V. C. Abbott, M.D., *Vice Chairman*
G. H. Agate, M.D.
R. T. Blackhurst, M.D.
J. R. Brink, M.D.
H. E. DePree, M.D.
A. F. Dundon, M.D.
C. M. Hansen, M.D.
E. H. Heneveld, M.D.
W. N. Herbert, M.D.
R. E. Rowe, M.D.

ANNUAL REPORT OF COMMITTEE ON IODIZED SALT—1962-1963

Our Committee has had a very busy year. At a meeting on October 4, 1962, at the Sheraton-Cadillac Hotel, plans were formulated for the coming year, and we have now seen the fruition of most of our projects.

At the MCI television program, which originated in Ann Arbor, a panel on thyroid disease was presented. Dr. Harry Towsley, who was chairman of the program, presented a fine discussion of the incidence of endemic goiter in Michigan and the importance of using iodized salt. This program enabled us to get our message across to a wide number of doctors.

Dr. W. H. Beierwaltes is continuing his surveys of the school children in Michigan and is planning further projects. Dr. J. K. Altland, of the State Health Department, with his team is also studying the utilization of salt in several counties.

Projects for the future include the completion of a movie which will be used as a teaching medium for schools. The restudy of the soil and water samples from the four original counties is being carried on through the kindness and cooperation of the Dow Chemical Company.

The Committee feels that the endemic goiter problem is still present and must be attacked continually if we are to keep the amount of goiter at a low level. The fact that thyroids involved with endemic goiter will later have a larger incidence of other thyroid disease makes this work very significant.

B. E. Brush, M.D., *Chairman*
J. K. Altland, M.D., *Vice Chairman*
W. H. Beirwaltes, M.D.
J. R. Carney, M.D.
W. S. Carpenter, M.D.
F. B. Levagood, M.D.
R. F. Powers, M.D.
H. A. Towsley, M.D.
R. L. Waggoner, M.D.
Milton R. Weed, M.D.

ANNUAL REPORT OF COMMITTEE ON LEGAL AFFAIRS—1962-1963

MSMS members have responded magnificently whenever called upon to express their views to state or national legislators. The 72nd session of the Michigan Legislature considered more proposals in a shorter time than has any recent session. The Governor, legislators, and Michigan congressmen have demonstrated rare understanding and a gratifying willingness to respectfully weigh the educated views of doctors of medicine in scientific matters. By assisting the lawmakers to evaluate proposals with medical implications, all members of the Society have contributed in the highly successful legislative session just completed.

During the 1963 legislative session, delegations of physicians from numerous county medical societies generously gave of their valuable time and advices in meetings with their State Senators and Representatives conducted at the MSMS headquarters building. The Committee wishes to express its sincere thanks to these many physicians for their valuable cooperation in making these informal information exchange meetings so mutually beneficial.

The Committee expresses its gratitude and appreciation to all who have cooperated with its efforts to assure a continuation of the best in health care and services for Michigan's citizens. The members of the Committee were continually impressed by the faultless and superior performance of the MSMS staff, particularly those most concerned with legal affairs.

A number of proposals that were endorsed and supported by MSMS were enacted into law in 1963. An even greater number of undesirable

health proposals were properly rejected by the lawmakers, who did not enact any legislation which was inimical to the best health interests of the people of Michigan.

General Committee Activity: The 1962 House of Delegates referred nineteen matters to the Legal Affairs Committee for implementation or study. Several of these involved proposed federal legislation and the resolutions of the House were immediately transmitted to the appropriate committees of Congress and to all members of the Michigan Congressional delegation. The remainder of the projects referred by the House dealt with state legislation and were all acted upon by the Legal Affairs Committee in accordance with the directives of the House.

The full Legal Affairs Committee held meetings in November of 1962 and in January and May of 1963. The Committee authorized its chairman to appoint a "nucleus group" from among its members to meet on call during the legislative session. This "nucleus group" met in February, March and April of 1963 and considered the more than 1,500 bills and resolutions introduced in the State Capitol. All recommendations of the "nucleus group" were transmitted to the full Committee and to The Council, MSMS. It was necessary for intensive study to be given to over fifty separate legislative proposals which were of particular importance to the practice of medicine.

A State Legislative Resource Kit was issued for the second successive year and given wide distribution among component societies. This kit contained background information regarding nine major legislative projects, the latest MSMS and AMA policy declarations regarding medical aid for the needy and the needy aged, and a revised roster of the Michigan Legislative and Michigan Congressional delegation.

During the three and one half months the legislature was in session, eight "Legislative Reports" were issued, at intervals of approximately ten legislative days, containing current information on both state and national legislative projects and progress. These reports reached approximately 850 physicians who were selected throughout the State by the component societies.

State Legislative Matters: Five resolutions were adopted by the 1962 House of Delegates which called for specific action by the Michigan Legislature. Two of these dealt with "Good Samaritan" legislation; a new Michigan law on this matter was enacted with the support of MSMS which will become effective in early September, 1963. Under its provisions physicians will be exempt from civil liability when rendering emergency care, unless in rendering the care they are guilty of "gross negligence or willful and wanton misconduct." A House of Delegates resolution directing that such a law extend the exemption to emergency care rendered during times of enemy attack or natural disaster was invited to the attention of the Legislature but the lawmakers felt it was not essential to incorporate this specific language in the statute.

Protective Health Measures for Boxers: House of Delegates Resolution No. 14 directed that legislation be sought to increase the authority of ringside physicians at boxing and wrestling matches. MSMS vigorously supported such a legislative proposal, testifying in its behalf before both Senate and House. On May 10 the Governor signed the new law which, by authorizing physicians to halt contests while they are in progress and by requiring more thorough physical examinations of athletes who are rendered unconscious, better safeguards the health of boxers and wrestlers.

Mental Health Legislation: The House of Delegates adopted a resolution seeking to require that at least two of the five-member State Mental Health Commission be qualified psychiatrists. A bill to accomplish this was introduced with Society endorsement and subsequently, through the passage of another proposal, the Legislature abolished the five-member Commission and substituted for it a twelve-member advisory council. MSMS prevailed upon the Legislature to provide that not more than five of the twelve members be physicians qualified in psychiatry or neurology, and to also provide that the twelve members serve for overlapping terms with the advice and consent of the State Senate. The Society also strongly supported a provision, adopted by the Legislature, that the Director of the State Department of Mental Health henceforth be a physician.

The 1963 Legislature also enacted a new "Community Mental Health Services Law" which was strongly supported by MSMS after thorough analysis by both the Society Legal Affairs and Mental Health Committees. In this new law, the Society successfully supported phraseology to the effect that where private facilities are available for mental health care, persons who can afford to use the private facilities shall not use the public facilities unless specifically referred to them by the courts, schools, or health or welfare agencies.

Legislative Veto of Administrative Rules: A proposal which passed the 1962 State Legislature but was vetoed by the Governor, to provide that any administrative rules developed by the state agencies would not become effective until approved by the Legislature, was endorsed by the 1962 MSMS House of Delegates. A similar proposal was reintroduced during the 1963 session, passed the House of Representatives, but failed of passage in the State Senate. In compliance with the directive of the House of Delegates, MSMS informed the Senate of the House's favorable opinion of the proposal, which had general application to all agencies of state government and did not specifically relate to health.

MSMS has sought for several years to prevail upon the Legislature to authorize the Michigan

Crippled Children Commission to reimburse hospitals for the full audited costs of care, and to reimburse physicians the full 1959 Uniform Fee Schedule for Governmental Welfare Agencies, for those served by the crippled and afflicted children programs. MSMS testified on several occasions regarding this proposal and the Legislature granted a measure of relief to both physicians and hospitals. Physicians are no longer limited to payment of no more than $200 for any one patient in any one year (as formerly) and may now render statements for their services within 45, rather than 30 days. The reimbursement formula for hospitals has been substantially improved. MSMS will pursue its request for full acceptance of the Uniform Fee Schedule for Governmental Welfare Agencies in the 1964 State Legislature.

Professional Corporations: MSMS was successful in 1962 in supporting the enactment of a new Michigan law to permit professional persons to incorporate and thus obtain the advantages of Kintner-type plans (retirement, insurance, tax computation, etc.) The Society again supported certain amendments to the 1962 law in the 1963 Legislative Session which have improved the Professional Corporation Law. The changes involve the permitting of voting trusts, corporate names, and the including of personal representatives and estates as shareholders for limited periods.

Seat Belts: MSMS' House of Delegates has long endorsed the use of seat belts on automobiles and the Society was gratified by the passage in the 1963 Legislature of a new law making the installation of seat belts on all new automobiles mandatory commencing with the 1965 model year. In 1962 the House of Delegates urged all physicians to set an example by using seat belts on their personal vehicles.

The Legal Affairs Committee took positive and fruitful action with regard to many other legislative proposals during the 1963 session, including (1) successfully urging the Legislature to appropriate sufficient funds so that out-patient facilities could be maintained at the Northern Michigan Sanatorium in Gaylord when that facility was transferred from tuberculosis to mental health programs; (2) proper amendment of a proposal to permit county health departments to fix and charge fees for sanitation services only, rather than all health services provided by such departments; (3) support of a law making gifts of human anatomy for medical purposes easier and more speedily accomplished; and (4) support of an amendment to the Workmen's Compensation Law permitting the State to pay hospitals and physicians directly on behalf of qualified persons, in the event of failure of the employer to make payment.

Fluoridation: MSMS strongly opposed a legislative proposal to the effect that no community could fluoridate water without a plebiscite. The Society testified in opposition to this bill in both the House of Representatives and the Senate, pointing out that such a law would seriously impair the utilization of a proven public health measure. This bill was not reported out of Senate committee.

The Society also took a strong position in opposition to a number of other proposals, testifying before appropriate committees in order to inform the legislators that these proposals were not in the best health interests of the people of Michigan. Among these bills, all of which were wisely rejected by the lawmakers, were (1) an anti-vivisection proposal; (2) a bill which would have authorized the State Labor Department to conduct inspections for "unhealthy" or "unsanitary" conditions in any premises (including hospitals); (3) proposals to require by law that a majority of the members of the board of Michigan Medical Service be "public representatives"; and (4) a proposal to legalize the practice of psychotherapy by psychologists.

The State Legislature considered numerous other health proposals, some of which passed the house in which they were introduced but failed to pass the full Legislature. Many of these will again come before the 1964 Legislature, including a proposal to create an advisory committee under the State Health Commissioner to deal exclusively with cancer quackery (not cancer control), a proposal to require a prescription for the purchase of paragoric, a proposal that Michigan engage in the Interstate Mental Health Compact, and a bill to permit either physicians *or* registered nurses *or* technicians under the supervision of physicians or nurses, to withdraw blood for chemical tests for intoxication. Bills again were introduced to examine and license physical therapists and dispensing opticians which were thoroughly analyzed by the Legal Affairs Committee.

State Government Reorganization: The adoption of Michigan's new Constitution requires that "all agencies and instrumentalities of state government and their respective functions, powers and duties be allocated by law among and within *not more than* twenty principal departments." Presently at least seventeen separate boards, agencies and commissions are directly or indirectly involved in health matters and must be combined into one or more principal departments. The MSMS Council has directed the Legal Affairs Committee to proceed on a continuing basis to work with all groups developing reorganizational recommendations and to provide the necessary factual information to enable The Council to formulate policies so that the eventual reorganization will serve the best health interests of the people of Michigan. This is a monumental task, involving liaison between the Legal Affairs Committee and most other MSMS committees, the State Legislature, the State Executive Department, state agencies, boards and commissions, the State Attorney General, and many health-oriented private groups.

Federal Matters: The King-Anderson Bill (HR

3920), is substantially the same as the King-Anderson Bill (HR 4222) of 1962. The federal administration again is strongly pressing Congress to pass a Social Security-financed hospital and limited medical care bill for all persons over the age of 65. All of the compelling reasons why such a program was undesirable under HR 4222 of 1962 are applicable in regard to this slightly modified 1963 version of socialized medicine under Social Security.

MSMS will again present oral testimony before the House Ways and Means Committee of Congress, if necessary, regarding the effort of the State Society to make the Michigan Medical Assistance to the Aged (MAA) program one of the finest in the nation. Toward this end the Legal Affairs Committee has cooperated with the appropriate officials in state government to modify the operating rules of the MAA program, so that it will function even better throughout Michigan, particularly in populous Wayne County. A rule change has been sought which will assure that MAA patients will not be deprived of the services of their private physicians and care in the hospitals of their choice, and considerable research has been done to provide factual information concerning the need for alteration in the present program. MSMS will continue to seek a constant improving of the MAA statute and to bend every effort toward continuing successful implementation of this program for providing complete medical assistance for those who need help in meeting the cost of medical care.

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Mrs. N. T. Pasternacki, *Advisor*

ANNUAL REPORT OF COMMITTEE ON MATERNAL HEALTH—1962-1963

The Committee on Maternal Health has completed another successful year in furthering its aims and purposes.

The first meeting was held Wednesday, October 31, 1962, at Women's Hospital, Ann Arbor, and planning for the spring conference on Maternal and Perinatal Welfare was begun. It was decided to investigate the possibility of a "Newsletter" that could be distributed to all physicians practicing Obstetrics in the State. The Medical Liaison Subcommittee was authorized to explore this avenue of improving the dissemination of information and data regarding perinatal and maternal health. The Subcommittee on Maternal Mortality reported a continuing decline in maternal deaths during 1961. It was also noted that the State Department of Health and various state hospitals were conducting a study program for the earlier detection of phenylketonuria.

The second meeting was held January 10, 1963, at MSMS Headquarters in East Lansing. Further discussion on the Newsletter advanced this program and the Committee was cheered by the splendid reduction of maternal deaths in Wayne County in 1961. The development of Perinatal Mortality Study Groups in as many hospitals as possible was discussed. Dr. Corneliuson reported that the State Department of Health was preparing a questionnaire and offer of assistance in furthering this program.

On May 23-24, 1963, the Committee in cooperation with the Michigan Department of Health held the second two-day conference on maternal and perinatal welfare. Sixty-five physicians were registered. Eleven papers were presented. James F. Donnelly, M.D., of the North Carolina State Department of Health was the guest speaker. This program was deemed highly successful and the Committee and those who attended voted unanimously to hold such a meeting again in 1964.

At the May 23 Committee meeting, preceding the conference, C. M. Bell, M.D., presented the material for the Newsletter which was approved and sent to The Council for study. Charles A. Behney, M.D., reported that 450 physicians throughout the State had attended meetings of the regional maternal evaluating committees and that two additional committees had been activated during the year, in Petoskey and Traverse City.

The Committee noted with regret that Charles A. Behney, M.D., was retiring from his position with the Michigan Department of Health and leaving the State. N. F. Miller, M.D., spoke of the valuable contributions that Dr. Behney had made in his eight years in the State and expressed the sentiments of all present in wishing Dr. Behney health and happiness in his retirement.

The Chairman wishes to express his thanks to the members of the Committee, the Department

of Health and the MSMS Headquarters personnel for their many valuable contributions through the year.

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Mary Lou Byrd, M.D., *Advisor*
F. A. Jones, M.D., *Advisor*
R. C. Bates, M.D., *Consultant*
A. James French, M.D., *Consultant*

ANNUAL REPORT OF COMMITTEE ON MEDICAL SOCIO-ECONOMICS—1962-1963

The Committee is pleased to report that it has been actively pursuing a program to develop long-range socio-economic plans for MSMS.

The first phase of this program has been implemented by the conducting of a series of Economic Workshops in various sections of the state—Oakland County, December, 1962 and January, 1963; St. Clair County, April, 1963; Northern Michigan, May, 1963. The Committee also conducted a "Survey of Opinions" in Kalamazoo in March, 1963. These activities were climaxed by a "Grand Workshop," MSMS Headquarters in East Lansing in June, 1963, which was composed of representatives from Economic Committees of component and specialty societies from all over the state.

These Workshops aimed to provide a forum for the expression of grass-roots opinion from MSMS member physicians regarding the critical socio-economic issues facing the private practice of medicine today. In a broad way the goal of the Workshops was to develop unifying beliefs, principles and guidelines in the socio-economic field for your State Society.

All Workshop sessions were conducted in an unstructured, free-wheeling manner. All ideas were welcomed. Sometimes the Workshop findings confirmed old ideals; sometimes new ideas were unearthed; sometimes questions of a serious nature were raised. Complete findings of the Workshop are on file in the MSMS Executive Office, perusal of which is invited and encouraged on the part of interested individuals. Reported here are some selected findings which the Committee found of particular interest.

Tenets of Beliefs and Principles

We stand for providing the best possible medical care for all citizens.

We believe in better medical care than can possibly be provided by Government.

We believe that this medical care should be provided for by individual resources and through private insurance plans.

We believe that medical care for our older people can be anticipated during their working years by accumulated premiums. This should be encouraged by tax credits.

We believe that the small segment of our people who are not able to participate in self-help programs should get help from state and local governments.

We believe that a free individual in a free society must have free choice to select his own physician and hospital.

Guidelines

The private practicing physician must avoid complacency because the future of private medicine in the United States is dependent upon how private medicine meets the challenge of today.

There is a high and continuing increase in the quality of care supplied by the medical profession in private practice. Individual professional excellence is dependent upon individual physician responsibility and private association.

The concept of first dollar coverage regarding hospital insurance results in the public's placing inordinate pressures on the private practicing physician to hospitalize patients.

Private medicine has a responsibility to the public to evaluate and review the use of public and federal funds used in medical research with the view of eliminating unnecessary and duplicated research.

The general practitioner must be given a place on hospital staffs.

We believe that medicine should continue, and encourage expansion of medical quality control by physician groups, such as tissue committees, audit committees, and utilization committees; we believe M.D.s must and should have a place on hospital boards and executive committees; we believe doctors have a responsibility to their profession and to their colleagues to participate in the work of hospital staff committees.

We recommend that MSMS inaugurate and coordinate short term preceptorship programs whereby interested physicians could arrange to have interested medical students, interns and residents

receive training in their offices. This program would be entirely voluntary.

One of the essential goals of the medical school is to educate general practitioners and upgrade the professional level of same.

Medical schools should be encouraged to assign curriculum time to the teaching of medical economics and more adequately prepare the student for private practice.

We object to any invasion of public health agencies into the private practice of medicine by the use of fright campaigns, federal funds, and public relations approaches.

The medical profession must give more recognition and support to the registered nurse, especially in the area of proper compensation for her professional abilities and skills.

MSMS Department of Medical Socio-Economics

The MSMS Department of Medical Socio-Economics, staffed by Richard M. Campau, Research Director, and Clyde T. Hardwick, Ph.D., Economic Consultant, had an extremely productive year. The Department ably assisted the Economic Committee in the aforementioned Workshops by preparing the Conferee Guides used therein. Doctor Hardwick assumed much of the discussion leadership responsibility.

Also, the Department undertook various research projects for many MSMS committees, and the Executive Office as highlighted below:

1. *MSMS Journal:* Special feature articles by Doctor Hardwick have appeared as follows: January, 1963—"Rainbow of Health Choices"; February, 1963—"The Economic Conservative." Articles by Mr. Campau have appeared as follows: May, 1963—"Physician Distribution in Michigan and the Nation"; April, 1963—"Health Care Spending in Detroit"; June, 1963—"Health and Medical Care Expenditures." Economic copy intended for THE JOURNAL is periodically reviewed by the Economic Department for accuracy and clarity.

2. *Challenge Magazine:* The January, 1963, edition of this publication of the Michigan Chamber of Commerce contained an article by Doctor Hardwick entitled, "Medicare—An Economist Looks at King-Anderson." The Michigan Farm Bureau has asked for permission to reprint this article and it has been granted.

3. *Research Bulletins:* The following Research Bulletins were published:

(1) No. 102—"Michigan Medical Assistance to the Aged Program Statistics"

(2) No. 103—"Income Statistics re Family Income of Noninstitutional Population"

(3) No. 104—"Characteristics of Michigan Population by County"

(4) No. 105—"Comparative Health Care Systems; Four Selected Countries"

(5) No. 106—"Summary of the New King-Anderson Bill and Economic Implications to Michigan Social Security Taxpayers"

(6) No. 202—"Cost of Health Care"

(7) No. 203—"Highlights From Report of Ad Hoc Committee on Medical Education"

(8) Special Report—"A Bird's Eye View of Blue Shield Rating"

4. *MSMS Committee on Occupational Health:* The Department carried out considerable research for this committee regarding Michigan's Workmen's Compensation Act. Much of this data were incorporated in the Committee's Report which was presented to the January 25-26, 1963 meeting of the MSMS Council.

5. *MSMS Ad Hoc Committee to Survey Utilization of Health Insurance:* Mr. Campau attended several meetings of this committee as a resource person. Several items of research materials were mailed to all members of the Committee to aid them in their deliberations.

6. *MSMS Medical Care Insurance Committee:* Considerable research was carried out for this Committee concerning MSMS House Resolution No. 11 of 1962 pertaining to changes of the Kerr-Mills Law. Also, the Department has been doing continuous work for this Committee on its many deliberations concerning Voluntary Health Insurance, especially Blue Shield.

7. *MSMS Ad Hoc Committee on Conferences on Health Care:* Mr. Campau attended meetings of this Committee in a resource capacity. Several mailings of research material were sent to all committee members.

8. *Attendance at Conferences:* The Department represented the Michigan State Medical Society at the following conferences:

Health Insurance Council (Detroit), April 30 and May 1, 1963

Group Health Institute (Detroit), May 9, 10, 11, 1963

9. *MSMS Committee on Legal Affairs and Public Relations Staff:*

A. *Michigan Medical Assistance to the Aged Program.* A study of this program was completed by the Economic Department. Many of the findings are now being utilized by the Public Relations Staff in its campaign to make this program more effective. The Department participated in testimony before the Wayne County Board of Auditors and the Wayne County Board of Supervisors, and in meetings with the Michigan Department of Social Welfare. Also much back-up data were prepared for the Public Relations Staff as an aid in their contacts with the Governor's office.

B. *Michigan Crippled Children Commission Fee Schedule.* Follow-up work was completed to bring last year's major study up to date. The Department participated in testimony before various Committees of the Michigan legislature regarding the upgrading of the present Commission Fee Schedule to the equivalent of Michigan Medical Service (Blue Shield) M-75 Plan "A" Schedule.

10. *Blue Cross-Blue Shield Public Hearings:* The Department developed the first draft of the MSMS testimony along with economic back-up. Mr. Campau and Mr. Riley, of the Public Relations Staff, assisted by Doctor Engelke (who represented MSMS) at the hearings in Detroit and Grand Rapids, February 4 and 8, 1963.

11. *Economic Data Cards for Wayne County Speaker's Bureau:* The Department prepared a set of cards giving medical economic statistical information in succinct form for members of the Wayne County Legislative Speaker's Bureau so that they might have such information readily available when on speaking engagements. Master sets of these cards have been made available to the Executive Secretaries of County Medical Societies for similar purposes.

12. *Miscellaneous Projects:* In addition, the Department provided help to individual MSMS Councilors and Officers by fulfilling requests for research data.

The Committee commends the Department for its fine work and is pleased that Mr. Campau was able to visit the following County Medical Societies on their respective State Society Nights to describe the activities of the MSMS Department of Medical Socio-Economics: Monroe, Jackson, Allegan, Hillsdale, and Branch, Livingston and Barry.

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ANNUAL REPORT OF COMMITTEE ON MENTAL HEALTH—1962-1963

The Mental Health Committee started the year with the report of the representatives to the first American Medical Association National Congress on Mental Health and Mental Illness. The Congress was attended by Z. S. Bohn, M.D., J. M. Dorsey, M.D., Benjamin Jeffries, M.D., W. H. Obenauf, M.D., E. R. Rodda, M.D., and R. W. Waggoner, M.D. The report was written by the Steering Committee from Michigan which consisted of representatives of the State Medical Society, the Michigan Society of Neurology and Psychiatry, the District Branch of the American Psychiatric Association and the Michigan Society for Mental Health.

The report stressed that the American Medical Association and the Michigan State Medical Society take a strong role in Mental Health affairs; that organized medicine assume active leadership in the training, recruitment and adequate utilization of medical, allied professional and community group resources. The report stated that the priorities in programming for Mental Health and Mental Illness are personnel, education, finance, research and legislation.

The full report is appended.

The Committee has interested itself, during the year, in ways and means of implementing the Congress recommendations.

The Committe is planning to have a meeting in the summer of 1963 of the chairmen of the Mental Health Committees of the County Medical Societies for the purpose of increasing local interest in Mental Health programming and to integrate State and County Society Activities.

The change in the administration of the State of Michigan raised immediate problems and questions relative to the leadership and policy making organization of the Department of Mental Health. Doctors Hirschfeld and Waggoner as a sub-committee, with the consultation of Doctors Gottlieb and Martin advised the committee.

In conferences with the Legal Affairs Committee, the Mental Health Committee supported legislation designating a Psychiatrist as Director of the Department of Mental Health and the changing of the Mental Health Commission to an Advisory Committee consisting of twelve members, of which not more than five are to be physicians, licensed in Michigan, and trained in either Psychiatry or Neurology.

In the late fall, the Committee reviewed potential legislation and recommended the favorable consideration of the Inter-State Compact for Mental Health which has been presented to the legislature for the past several years. This legislation was partially successful but was not ultimately enacted. We anticipate that in another year we may be able to have the legislature consider this favorably.

The Mental Health Committee appointed a subcommittee, chaired by Doctor Rodda and consisting of Doctors Dorsey, Hershey and Jeffries, to study the legislation concerning community mental health services. It was recommended by the subcommittee and approved by the full committee that this legislation should be supported by the State Medical Society. Conferences were participated with the Legal Affairs Committee and at their invitation, members of the legislature and State Administration discussed these matters.

The efforts of the State Medical Society were of importance in the enactment of this legislation. Members of the Mental Health Committee were active in seeing that this legislation was not compromised or distorted by unwise amendment.

The AMA Council on Mental Health held its ninth annual conference of Mental Health Representatives of State Medical Association in Chicago. This was attended by Doctor Jeffries, Chairman of the Mental Health Committee, Warren F. Tryloff, Assistant to the Executive Director of the Michigan State Medical Society, and Mr. Charles Wagg, Acting Director of the Michigan Department of

Health. This was a noteworthy meeting in that during this meeting there was an approval of the President of the United States' Mental Health message to the Congress. Mr. Boisfeuillet Jones, Special Assistant for Medical Affairs, Department of Health, Education and Welfare, discussed the Federal Programs to implement State Mental Health programming. Further, there was an opportunity to discuss with the acting director of the Department of Mental Health the status of plans for a planning program which would be funded by the National Institute of Mental Health.

This meeting was reported to the Mental Health Committee and is appended.

The Mental Health Committe held five meetings from the period of October, 1962 until June of 1963.

The Chairman wishes to commend the members of the Committee for their excellent contributions.

Recommendations

1. That the MSMS and Mental Health Committee continue the progress in implementing the policies of the AMA Council on Mental Health and the AMA Congress on Mental Illness and Health.
2. That the MSMS and Mental Health Committee study carefully, and be actively involved in the development of community Mental Health Services.
3. That the Mental Health Committee follow closely the new developments in the Michigan Department of Mental Health.
4. The MSMS continue to actively support the Interstate Compact for Mental Health.
5. That the MSMS be represented and actively involved in the state-wide planning for Mental Health projected by the Michigan Department of Mental Health.
6. That the Michigan Department of Mental Health continue to be an autonomous department in the forthcoming reorganization of the executive branch of the State Government of Michigan, as provided in the new Constitution for the State of Michigan.

Benjamin Jeffries, M.D., *Chairman*
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R. W. Waggoner, M.D.

Report of the Michigan Delegation to the AMA Congress on Mental Illness and Health

The delegation of the Michigan Region of the AMA Congress on Mental Illness and Health strongly endorses the AMA principles on mental health and urges prompt implementation through appropriate action of these principles at all levels of organized medicine and allied professions.

We recommend to The Council of the Michigan State Medical Society that it direct its Committee on Mental Health to establish ad hoc sub-committees to encompass the topical subject areas of the AMA National Congress on Mental Illness and Health.

Priorities—The Michigan delegation considers the top priority problem areas in mental illness and mental health to be personnel, education, finance, research and legislation, in that order.

The AMA and Michigan State Medical Society must take a strong role in mental health manpower affairs. Organized medicine must assume active leadership in the training, recruitment and adequate utilization of medical, allied professional and community group resources.

Education—Organized medicine must explore, promote and support programs of education along two broad fronts. These are:

1. The communicating of mental health knowledge.
 a. Within the profession of medicine.
 b. From the profession of medicine to the public at large, as well as educators, boards of education and students at all levels from elementary school through college.
2. The education and training of all needed personnel, including all physicians, dentists, nurses, social workers, psychologists, and others in the health field.

Endorse Principle—We strongly endorse the stated AMA principle of multiple source financing. We recognize the need for additional expenditures at all levels, federal, state and local, with emphasis on local community sharing of responsibility.

Voluntary insurance and prepayment health care programs should be expanded on a basis analogous to ordinary medical and surgical benefits.

Research—Convinced that the most important long term results in mental health will accrue from research, we urge the AMA and the Michigan State Medical Society to stimulate and support effective programs, utilizing the staffs and facilities, not only of the universities, but also of the Department of Mental Health.

Legislation—We agree with the AMA statement that hospitalization for the treatment of a mental condition should not be the equivalent of an adju-

dication of incompetency. We also agree that all legal rights of the mentally ill must be protected. Therefore, we recommend further study in cooperation with the State Bar of Michigan, of possible changes in the laws to accomplish these ends.

We also urge study of the feasibility of Community Mental Health Services legislation.

In the implementation of the foregoing projects, the important work that the Women's Auxiliaries already are doing should be recognized and further encouraged.

We wish to commend the AMA for calling the First National Congress on Mental Illness and Health. We are convinced that the meeting will result in considerable worthwhile progress in treatment and prevention of mental ailments. We recommend that a second such congress be called within two years.

Report of the Ninth Annual Conference of Mental Health Representatives of State Medical Associations

(Sponsored by AMA Council on Mental Health)
March 1-2, 1963
Chicago

Benjamin Jeffries, M.D.
MSMS Mental Health Committee Chairman

Participants: Invited guests included AMA staff and Council on Mental Health, Directors of State Mental Health Departments, Chairmen of State Medical Society Mental Health Committee, and representatives of Executive Staff.

Those from Michigan were: Benjamin Jeffries, M.D., MSMS Mental Health Committee Chairman; Mr. Charles Wagg, Director, Michigan Department of Mental Health; Mr. Warren F. Tryloff, Assistant to the Executive Director, MSMS.

Purposes of this meeting:

1. To identify how M.D.'s can function more efficiently to implement their mental health programs.
2. To mesh plans of M.D.'s, State Mental Health Directors, and State Societies.
3. To review the revolution in the care of the mentally ill.
4. To review national legislation regarding mental health and mental retardation.
5. To discuss the future role of the general hospital in mental health plans and to discuss ways of enlarging the role of the non-psychiatry M.D. in the care of the mentally ill.

Conference Program: The Federal Government's Mental Health Program was detailed by Mr. Boisfeuillet Jones, Special Assistant for Medical Affairs, Department of Health, Education and Welfare.

The national program is proposed in these basic areas:

1. Development of local comprehensive mental health centers, on a shared cost basis.
2. Improvement of quality of care in state mental institutions, through special demonstration projects.
3. Expansion of research and training of auxiliary personnel.

If adopted, the national program would be administered locally by a state plan. Construction grants would be handled in a manner similar to Hill-Burton funds.

Regional discussions were held with representatives of states by areas on:

1. How can the program of state societies and state mental health departments be best effected in mutual support and avoidance of conflict.
2. How to establish effective mechanisms for permanent liaison between the State Society, the Mental Health Department and mental health groups.
3. The role of and training for non-psychiatric resources.

Review of Federal Planning Funds Available to States in 1963: A total of $4.2 million has been made available to the states to help them formulate plans for comprehensive mental health programs. These funds to be administered by the recognized Mental Health Authority in each state must be matched by the state on a dollar for dollar basis. The minimum amount granted per state is $50,000. Michigan may obtain $137,800 without an additional appropriation since current budget includes funds which qualify for matching purposes.

The prime purpose of these grants will be to assist each state in formulating mental health programs which have their roots in the community.

An initial step in securing a planning grant will be for each state to submit a "plan for planning" to the Public Health Service. This will be assessed by the service as a basis for approving the grant. The target date for submission of Michigan's "Plan for Planning" is April 1.

Criteria for the community programs would include a broad range of mental health services emphasizing continuity of care—including preventive services, early diagnosis, treatment and aftercare for discharged hospital patients.

The programs should also include coordinating of the plans and efforts of all community agencies and organizations with an interest in mental health and should be aimed at both the prevention of mental illness and the promotion of mental health.

States are also expected to take into account such diverse areas as the need for facilities and services, research and training, and legislation and financing. The States are to develop priorities for short and long-range activities and to outline and document their need for new and expanded programs.

The funds for this new Federal grant-in-aid program were appropriated by the 87th Congress in its action on the 1963 budget for the National Institute of Mental Health.

Recommendations Regarding Role of MSMS in Mental Health Program: A full and detailed report of this Conference will be presented to the MSMS Mental Health Committee. Any recommendations resulting therefrom will be presented to The Council for official approval.

ANNUAL REPORT OF ADVISORY COMMITTEE TO MICHIGAN STATE MEDICAL ASSISTANTS SOCIETY—1962-1963

The Advisory Committee to Michigan State Medical Assistants Society has had no formal meetings during the past year. Because of the illness of the President of the Michigan State Medical Assistants Society, there was considerable decrease in activity of that organization. She was replaced in early 1963, and the new President and I have been in close contact with each other since that time.

I do not believe that the organization has suffered particularly, but rather feel that under the new leadership it is again assuming its growth and importance.

Your Chairman humbly calls attention to resolutions passed by this Committee every year in recent years requesting that space be found for the office of this organization under the roof of the Michigan State Medical Society. Very little space would be required—scarcely more than room for a desk, a filing cabinet and a telephone. The benefit that will accure to the State Society and the individual doctors will be considerable.

G. E. Millard, M.D., *Chairman*
R. L. Green, M.D.
H. C. Tellman, M.D.
T. J. Trapasso, M.D.

ANNUAL REPORT OF COMMITTEE ON OCCUPATIONAL HEALTH—1962-1963

1. Two Committee meetings were held—December 7, 1962, and February 26, 1963.

2. A policy regarding laboratory and x-ray procedures in non-occupational cases, amended by our Committee from Doctor Jend's proposal to the Wayne County Medical Society, was recommended to the MSMS Council for approval with copies to be forwarded to AMA.

3. A series of one-page articles on Occupational Health from California Medical Association's "California Medicine," was recommended for publication in MSMS Journal following proper clearance and review.

4. The Subcommittee on Medical Service in the Small Plant met May 14 and will report to full Committee at their next meeting.

5. The MSMS Council gave special commendation to the Sub-committee's report recommending six broad recommendations to correct problems from broadening scope and coverage of workmen's compensation legislation and adopted their recommendation for appointing a special ad hoc study committee to attempt solution. Our Sub-committee will next study pregnancy leave policy, equitable administration of compensation laws, and second-injury questions.

6. The MSMS Council approved our Committee's recommendation on tetanus immunization as official policy of the State Medical Society. The same policy was subsequently approved by the Michigan State Department of Health.

E. A. Irvin, M.D., *Chairman*
Edwin DeJongh, M.D., *Vice Chairman*
S. E. Andrews, M.D.
D. L. Block, M.D.
T. I. Boileau, M.D.
P. E. Derleth, M.D.
L. E. Filkin, M.D.
J. H. Ganschow, M.D.
H. L. Gordon, M.D.
A. E. Heustis, M.D.
William Jend, Jr., M.D.
M. W. Jocz, M.D.
H. J. Magnuson, M.D.
C. P. McCord, M.D.
R. D. Mudd, M.D.
O. J. Preston, M.D.
D. M. Richmond, M.D.
N. W. Scholle, M.D.
L. W. Staudt, M.D.
S. D. Steiner, M.D.
A. H. Whittaker, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE OF PAST PRESIDENTS—1962-1963

The Past Presidents of the Michigan State Medical Society met on September 27, 1962, Otto K. Engelke, M.D., acting as Chairman.

This Committee made the following recommendations:

1. That the tradition be continued that the honorary chairman be the eldest past president in seniority and that the acting chairman be the youngest in seniority.

2. Past Presidents Committee meeting should continue to be held as a Thursday noon luncheon meeting during the MSMS Annual Session.

Having conducted all of its business sitting as the Centennial Committee, members of the Committee renewed old friendships at an informal luncheon.

Otto K. Engelke, M.D., *Chairman*
L. J. Hirschman, M.D., *Honorary Chairman*
Otto O. Beck, M.D.
H. R. Carstens, M.D.
Henry Cook, M.D.
B. R. Corbus, M.D.
H. H. Cummings, M.D.
Milton A. Darling, M.D.
Wilfrid Haughey, M.D.
R. J. Hubbell, M.D.
L. W. Hull, M.D.
W. A. Hyland, M.D.
K. H. Johnson, M.D.
W. S. Jones, M.D.
R. L. Novy, M.D.
J. M. Robb, M.D.
G. B. Saltonstall, M.D.
E. F. Sladek, M.D.
G. W. Slagle, M.D.
C. E. Umphrey, M.D.
Arch Walls, M.D.

ANNUAL REPORT OF COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION—1962-1963

The Committee on Postgraduate Medical Education met on July 12 and December 6, 1962 and reviewed the postgraduate program. Many reports from chairmen and other physicians in the various centers have been received. Consideration has been

given to the comments and suggestions pertaining to the program. The subjects presented, attendance, and speakers on the program were as follows:

Centers	*Fall*	*Spring*	*1962-63*
Alpena	23	23	28
Battle Creek	93	44	104
Bay City	—	50	50
Cadillac	—	34	34
Grayling	14	10	16
Jackson	—	47	47
Lansing	134	76	160
Midland	45	39	62
Muskegon	68	61	90
Niles	60	26	62
Petoskey	19	27	32
Port Huron	—	35	35
Traverse City	31	—	31
Upper Peninsula			
Escanaba	17	19	21
Houghton-Calumet	7	13	14
Iron Mountain	13	16	18
Ironwood	14	12	15
Marquette	33	31	40
Menominee	25	14	28
Sault Ste. Marie	15	19	25
	611	596	912

The subjects presented during the year were:

Fall

Carcinoma of the larynx
Clinical considerations in sub-endocardial infarction
Congenital anomalies
Fracture and dislocation of the cervical spine
Hypertension
Management of the elderly confused patient
Masses of the neck
Multiple injuries patient
Pediatric surgery
Present trends in immunization
Problem drugs today
Problems in management of hepatic coma
Recent developments in cardiovascular surgery
Rehabilitation in medical practice
Septic shock
Strokes
The evolution of management of neoplasms of the female reproductive system
The legal implications of mysterious deaths and injuries
The present use of tranquilizers
The use and abuse of corticosteroids
Treatment of malignant lymphoma, with particular reference to leukemia

Spring

Acute surgical emergencies in infants
Cerebro-vascular diseases
Common chest diseases in medical practice
Dermatological manifestations of systemic disease
Gastro-intestinal diseases
Medical and surgical management of disease of gastro-intestinal tract
Ophthalmological manifestations of systemic disease
Pediatric poisoning
Recognition and management of fungus infection
Rehabilitation in medical practice
Respiratory infections in children
The diabetic child
The legal implications of mysterious deaths and injuries
The management of the advanced malignant patient
The physician's role in the prevention of juvenile delinquency
The treatment of oliguria in the community hospital
Thyroid disease. Management of thyroid nodules.

The following-named physicians participated in the teaching program:

Robert W. Bailey, M.D., Benjamin Barenholtz, M.D., Clifford D. Benson, M.D., Robert J. Bolt, M.D., Edward A. Carr, M.D., Frank Cullis, M.D., Arthur C. Curtis, M.D., Marion S. DeWeese, M.D., Reed O. Dingman, M.D., Harold F. Falls, M.D., F. Bruce Fralick, M.D., William J. Fry, M.D., John R. G. Gosling, M.D., Robert H. Gregg, M.D.

John P. Harm, M.D., E. Richard Harrell, Jr., M.D., Robert C. Hendrix, M.D., Fred J. Hodges, M.D., Robert D. Johnson, M.D., Robert F. Johnston, M.D., Richard D. Judge, M.D., Richard O. Kraft, M.D., Joseph E. Lenzo, M.D., George H. Lowrey, M.D., Kenneth R. Magee, M.D., John Stirling Meyer, M.D.

Muriel C. Meyers, M.D., Reed M. Nesbit, M.D., Raymond Read, M.D., J. Walden Retan, M.D., Richard C. Schneider, M.D., Maurice H. Seevers, M.D., John M. Sheldon, M.D., Herbert E. Sloan, M.D., Bruce H. Stewart, M.D., Donita Sullivan, M.D., Harry A. Towsley, M.D., Jack C. Westman, M.D., Walter M. Whitehouse, M.D., James L. Wilson, M.D., Walter P. Work, M.D., George D. Zuidema, M.D.

Intramural Courses	*Attendance*
Allergy	45
Anatomy	34
Basic Sciences and their Clinical Correlation	52
Cardiac Resuscitation	30
Clinical Conferences in Surgery	20
Clinical Internal Medicine	46
Diseases of the Blood	11
Diseases of the Heart	44
Electrocardiographic Diagnosis	49
Electrocardiography and Heart Disease	27
Endocrinology and Metabolism	63
Infertility and Endocrinology	71
Interns and Residents	405
Neurology	26
Obstetrics and Gynecology	116
Ophthalmology	210
Otorhinolaryngology	22
Pathology Slides, Surgical	22
Pediatrics	45
Physical Medicine	15
Prothrombin Testing (technologists)	16
Psychiatry	10
Psychiatry for Pediatricians	9
Pulmonary Diseases	26
Radioactive Isotopes, Clinical Use of	22
Radiology, Diagnostic	58
Recent Advances in Surgery	33
Rheumatology	18
Selected Clinical Topics	24
Therapeutics, Recent advances in	66
Medical Aviation Seminar	47
Tuberculosis Control Conference	70
The Brain in Relation to Systemic Disease	320
Genetics and Epidemiology of Chronic Disease	150
Kidney Disease Symposium	350
The Diagnostic Process	52
	2624

The reports from the extramural centers on the programs and attendance were reviewed by the Committee and comparison made with the report for the previous year. It was felt that the 1962-63 program had been very satisfactory. The annual clinic days at Battle Creek in the fall and Bay City in the spring were well attended by the physicians in the areas. It is planned to continue and establish these clinic days in centers wherever feasible.

The members of the Committee and guests at both meetings suggested a large number of topics which they thought might be of interest to practicing physicians. This backlog of suggested subjects for incorporation into programs at future dates has been very helpful to the chairman in implementing the presentations for different centers.

The Committee is deeply grateful to all the physicians who have participated in this program for their excellent teaching contribution, and to the support and encouragement given the program by the Michigan Department of Health, the Wayne State University College of Medicine, and the University of Michigan Medical Center.

J. M. Sheldon, M.D., *Chairman*
J. R. Heidenreich, M.D., *Vice Chairman*
R. J. Bing, M.D.
E. I. Carr, M.D.
G. O. Clifford, Jr., M.D.
Otto K. Engelke, M.D.
K. H. Johnson, M.D.
C. H. Ross, M.D.
R. M. Stow, M.D.
D. I. Sugar, M.D.
H. A. Towsley, M.D.
S. B. Winslow, M.D.
J. A. Witter, M.D.
H. H. Cummings, M.D., *Advisor*
M. A. Darling, M.D., *Advisor*
A. E. Heustis, M.D., *Advisor*
W. N. Hubbard, Jr., M.D., *Advisor*
G. H. Scott, Ph.D., *Advisor*

ANNUAL REPORT OF COMMITTEE ON PUBLIC HEALTH—1962-1963

Inasmuch as the membership of the Public Health Committee is made up, with three exceptions, of the chairmen of many other committees whose interest lies mainly in the various activities of patient care, and also inasmuch as the reports of the activities of these committees are sent directly to The Council and will be published individually in the Handbook for Delegates, only general comments will be made of the activities of these committees.

The members of the Public Health Committee reported much activity by their various Committees. Such activities were approved by the Public Health Committee and the chairmen commended for the interest as demonstrated.

The Committee members continued their interest in the activities of some of its component committees in the development and use of diagnostic cards, and urged continuation in those realms where feasible.

The Public Health Committee recommended to The Council that it endorse the A.M.A. International Health Program and that all means of communication be used to apprise MSMS members of this activity using such means as The Journal of the MSMS and the MSMS County Societies Letter.

Three resolutions adopted by the House of Delegates at the last Annual Session were referred to the Public Health Committee.

The resolutions and report of the Committee to The Council were as follows:

Resolution No. 8. The Committee felt that any attempt to evaluate the medical care patients received in physician's offices or patient's homes would not be feasible at this time for the following reasons:

1. The probable unwillingness of patients and physicians to provide the data necessary for evaluation of the type of care given.
2. If data was provided, who is to judge whether treatment is adequate and proper?
3. Because of the many intangible human factors involved in patient care, any evaluation given by a third party would be meaningless.
4. Assuming that pertinent data was obtained through some type of survey, what can we hope to do with the findings?
5. Any proposed survey should be made by unbiased non-medical personnel who are experienced in this type of study. Professional organizations of this kind are available for a fee but it is doubtful whether the Medical Society would be willing to appropriate a sum of money for this purpose.

We recommend, therefore, that The Council review the results of the Kalamazoo and Blue Cross studies. Our Committee feels that these surveys provide sufficient data to show that those patients interviewed were satisfied with the care given by their physicians. If a broader evaluation is thought necessary, funds might become available through one of the Foundations.

In discussing this Committee's report, the following statement was made and ordered to become part of the Committee's report: "The morbidity and mortality statistics today indicate that medical care is good."

Resolution No. 19. It is felt that Resolution No. 19 of the 1962 House of Delegates, entitled "Function of Public Health Service," does not completely interpret the functions of the state and local health departments and the Committee feels the statement "Public Health in Relation to the Private Practice of Medicine," as adopted by the November 1962 AMA House of Delegates, more adequately covers the functional role of state and local health departments. The Committee also feels there are statutory responsibilities of state and local health departments that must be observed.

Resolution No. 60. The Committee on Public Health was agreed there is merit in Resolution No. 60 and recommends to the MSMS Council that a committee be formed immediately to study this matter.

No action was taken on this by The Council because other MSMS Committees are already involved in the study and The Council has endorsed an overall study plan.

The Purposes and Personnel of the Public Health Committee were considered at length at both meetings with the recommendation sent to The Council that although the "Purposes" of the

Committee on Public Health, as set forth in the MSMS Bylaws, are good, the constituency of the Committee is not sufficient. The Committee recommends that the composition of the Public Health Committee should be made up of representatives of the State Health Commissioner, public health officers, and private practitioners, not necessarily chairmen of other health committees. Also, that the policy of listing MSMS health committees as Subcommittees of the MSMS Public Health Committee in the MSMS Bylaws, is not realistic.

The Committee on Public Health invited to the attention of the MSMS Council, Resolution No. 6 entitled "Establishment of Full-time Chairs of Preventive Medicine and Public Health," adopted by the 1957 MSMS House of Delegates. This Committee feels that some of the lack of communication between the public health profession and private practitioners of medicine in Michigan, in the long run, may be changed by having private practitioners of medicine present to medical school classes in public health, ways in which the two fields can cooperate.

O. D. Stryker, M.D., *Chairman*
B. E. Brush, M.D.
S. E. Chapin, M.D.
J. H. Fyvie, M.D.
W. G. Gamble, M.D.
A. E. Heustis, M.D.
E. A. Irvin, M.D.
W. W. Jack, M.D.
Benjamin Jeffries, M.D.
W. M. LeFevre, M.D.
G. H. Lowrey, M.D.
R. L. Mainwaring, M.D.
A. Hazen Price, M.D.
R. L. Rapport, M.D.
J. R. Rodger, M.D.
J. M. Sheldon, M.D.
R. H. Trimby, M.D.
H. J. VandenBerg, Jr., M.D.

ANNUAL REPORT OF COMMITTEE ON PUBLIC RELATIONS—1962-1963

In addition to the public relations activities recited in the Annual Report of The Council, and in addition also to the assistance given many of the scientific and socio-economic committees, MSMS has carried on a public informational program designed to demonstrate the concern of our profession for the public welfare and to increase public understanding of the professional principles which govern the work of the practicing doctor of medicine.

Television: In cooperation with the Michigan Association of the Professions and the Michigan Health Council TV program entitled "Decisions—The Moment of Truth," which appears each week over WJBK-TV, Channel 2, Detroit, the MSMS presented the following doctors: John W. Rice, M.D., Jackson; Alfred H. Whittaker, M.D., Detroit; Wyman C. C. Cole, Sr., M.D., Detroit; Edgar E. Martmer, M.D., Detroit; Clarence I. Owen, M.D., Detroit; James J. Lightbody, M.D., Detroit; Norman H. Parmalee, M.D., Roseville; Earl F. Wolfman, Jr., M.D., Ann Arbor; Sidney A. Chapin, M.D., Dearborn; Robert W. Bailey, M.D., Ann Arbor; John J. Rawling, M.D., Flint; Robert K. Nixon, M.D., Detroit; J. K. Altland, M.D., Lansing; Don W. McLean, M.D., Detroit; Muir Clapper, M.D., Detroit; E. A. Irwin, M.D., Detroit; Robert L. Novy, M.D., Detroit; Joseph L. Posch, M.D., Detroit; Donald N. Sweeney, Jr., M.D., Detroit; Horace L. Weston, M.D., Detroit; R. Wallace Teed, M.D., Ann Arbor; and Kenneth L. Krabbenhoft, M.D., Detroit. This program presents the doctor of medicine in a conversational setting discussing with the aid of a moderator and various visual aids, the aspects of medical practice that are of concern to the profession and interest to the public.

Radio:

Medical Journal: A program of a highly technical professional nature broadcast once a week on WDTM-FM, by a select group of physicians on the Wayne State College of Medicine faculty. The program is aimed at M.D.s and para-medical personnel. At the request of WDTM, our office devised a questionnaire which was sent to a cross sampling of M.D.s in the Detroit area, and in addition, conducted a telephone survey in order to determine the desirability and effectiveness of this scientific program.

Ask Your Neighbor: Early in 1963 we began work with the program director of WWJ radio station to devise a daily listener-participation health segment, utilized in the five day per week "Ask Your Neighbor" show. Plans were completed in April, with physician participation beginning May 6, 1963.

Motion Pictures: Progress has been made toward the preparation of a film which will be used on the 100th anniversary of the MSMS but the major activity in this medium has been the distribution of films produced by the AMA and MSMS. A total of 23 different films has been distributed through the Public Relations Library Service of MSMS and these have been used at every variety of meeting such as school groups, PTAs, women's groups, service clubs, television, etc.

News Media: Press releases to all Michigan newspapers, radio and TV stations carried reports of the work and policies of MSMS to the general public. The work of the staff with the newspapers is never-ending. It is highlighted by special work done under the direction of the press committees at the Annual Session and M.C.I. Also meetings with the communications media were held in several localities in the state in concert with the county medical society of the area. These have resulted, in most instances, in more mutually profitable arrangements for the dissemination of accurately reported news.

Speakers: Throughout the year the MSMS, its component societies, and its staff served the schools, colleges, service clubs, ancillary groups, ladies' societies, etc., with a steady flow of speakers. These

speakers have covered socio-economic areas as well as scientific material. In Detroit alone an average of seven physician speakers were booked each month. In addition high school science, pre-med clubs and guidance classes were serviced. A special meeting was arranged for representatives of student medical associations and para-medical groups to hear Dr. Edward R. Annis, President-Elect of the AMA.

Pamphlets and Publications: Distribution of both AMA and MSMS originated publications was maintained at a slightly lesser pace than last year in keeping with the diminution of crisis action in the socialized medicine controversy. Many legislative and other special bulletins were issued and helpful assistance rendered the MSMS Women's Auxiliary in the publishing of *The Auxilium*. The special card comparing the Kerr-Mills Act with the King-Anderson bill and the "Planning Your Career as a Medical Associate" were the two most widely requested pieces of literature produced by MSMS. Special action has been taken to meet the demand of the high schools for material in socialized medicine this year 1963-64, it being the major topic for high school debates. Major distribution points other than doctors' offices were the MSMS exhibits at fairs.

Exhibits: In 1962, the Michigan State Fair and in 1963 the Kent Health Fair, and the Saginaw County Fair were the public fairs where MSMS presented exhibits, with the usual exhibit at the State Fair being foregone in 1963 to save funds which are to be used at the 1965 Health Fair as part of the 100th anniversary. The MSMS exhibits are in excellent condition and were well received at the M.C.I. and Annual Session, as well as at the fairs noted. At the request of the Wayne County Medical Society the MSMS Detroit office planned and set up the exhibit at the 1962 International Freedom Festival held in Cobo Hall.

Intra-Professional Liaison: The visits of MSMS officers and fieldmen to county medical societies has kept pace this year with previous years and the visits of the President of MSMS to county medical societies accompanied by staff personnel increased. In the future even greater liaison between county, state and national as well as with specialty (including G.P.) groups is desirable.

Inter-Professional Liaison: The movement to associate the professions begun with the Michigan Association of the Professions is fast becoming nationwide in scope. New York, North Carolina, Illinois and several other states have, or are in the process of incorporating and organizing similar associations. Again this year February was designated Professional Week and so proclaimed by Governor Romney and many mayors of Michigan cities. The following has been carried out by MAP during 1962-63:

1. MAP has been successfully organized and financed. An American Association of the Professions is in the process of organization and has now been incorporated.

2. MAP organized and carried out a strong "Get Out the Vote" campaign in November of 1962 that has been recognized as the outstanding campaign of this variety in the state.

3. Four successful Congresses of the Professions have been held thereby advancing professional relationships. At the last Congress the program included the present governor and a former governor, two United States senators, two congressmen, several state officials, university presidents, the presidents of six national professional associations, thirty-nine distinguished speakers in all. Approximately 1000 people attended—704 of which were professional men and women.

4. Eight professions have been admitted to MAP representing a total of over 90,000 professional people in Michigan. The latest association to ally themselves with MAP is the Michigan Education Association. Professions now represented in MAP are: Architecture, Dentistry, Education, Engineering, Law, Medicine, Pharmacy and Veterinary Medicine.

5. Clarifying changes were made in the "Professional Service Corporation Act" by the Legislature. The Act was originally introduced by MAP in 1962. Strong support was given opposition to a bill which would have slowed the fluoridation of water in Michigan. Several resolutions in support of policies endorsed by medicine were approved at the Congress and are being implemented by contact with Congress and the Legislature.

6. One hundred thirty-five television programs depicting professionalism in its highest sense have been telecast over WJBK-TV, Channel 2, Detroit.

7. Meetings with school teachers, guidance counselors and high school students interested in the professions have been held in various areas and literature re the professions supplied schools.

8. The following business services have been successfully organized: Group Term Life, Major Medical and Group Disability Insurance, Office Furniture Leasing.

9. *Monitor*, Journal of the Professions, and its accompanying Supplement are being published on a 12-month basis.

Inter Health Organization Liaison: Directional and cooperative services were carried out in connection with the Michigan Health Council during the entire year. Through that organization close contact was kept with the Michigan Commission on the Aging. The MHC has carried forward for the second year its coordinated Home Care Program and continues its effective M.D. Placement Service. It has been especially helpful in matters of radio, TV and newspaper publicity. It is also carrying on a study of unnecessary overexposure to ionizing radiation. One of its future projects toward which considerable attention has been pointed is the development of a health museum. In addition to MHC close contact has been had with other major health organizations in Michigan and also with the pharmaceutical industry and profession.

Public Relations Conferences: The MSMS Annual Seminar, formerly known as the County Secretaries-Public Relations Seminar was held in Lansing in January. In spite of the extreme cold an excellent attendance coupled with an outstanding roster of speakers elicited an enthusiastic response. Any number of conferences were participated in by MSMS members and staff during the course of the year, all looking toward improving the image of the profession. Various special projects were also carried out, among them the publicization of June as Immunization Month. This began with the activity of Wayne County and was subsequently spread state-wide.

Present and Future Programming: The valuable delineation of policy known as the President's Program which was adopted by the House of Delegates served in 1963 and will in 1964 continue to serve as a guiding set of principles for MSMS public relations efforts. This program has provided a statement of concern for the people's welfare and ways and means of demonstrating that concern.

It is vital, however, that at an early date long-range thinking be carried out in concert between various committees of MSMS to give direction as a kick off to the second century of activity of this Society. This thinking will play a major part in the planning for the 100th anniversary of the MSMS which, of course, will review the progress made in that hundred years but must also look to the future.

The Public Relations Committee recognizes the necessity for continuing a very active campaign to resist socialized medicine legislation and to that end is urging the county medical societies to embark upon the American Medical Association recommended campaign known as OPERATION HOMETOWN. This will gain momentum during the remainder of 1963 and reach its highest point of effectiveness during the first six months of 1964.

However, the Public Relations Committee also notes the necessity for county medical societies, in addition to their efforts against socialized medicine, to inaugurate public service programs at every opportunity. Through these the profession can constantly refill the reservoir of public approval of our professions' major objectives—namely to guard, preserve and promote the health of the people.

R. W. Teed, M.D., *Chairman*
A. G. Gwinn, M.D., *Vice Chairman*
R. E. Anderson, M.D.
S. E. Andrews, M.D.
R. S. Bailey, M.D.
A. L. Benedict, M.D.
F. C. Brace, M.D.
J. W. Bunting, M.D.
W. L. Cain, M.D.
R. D. Cecconi, M.D.
D. R. Drew, M.D.
R. J. Fles, M.D.
R. A. Frary, M.D.
W. G. Gamble, M.D.
W. R. Gladstone, Jr., M.D.
Everette Gustafson, M.D.
C. M. Hanson, M.D.
L. T. Henderson, M.D.
B. E. Henig, M.D.
Joseph Hickey, M.D.
H. C. Hill, M.D.
D. B. Hiscoe, M.D.
S. L. Hoffman, M.D.
D. P. Hornbogen, M.D.
David Kahn, M.D.
G. T. Kelleher, M.D.
R. C. Kingswood, M.D.
J. L. Leach, M.D.
W. K. Locklin, M.D.
E. C. Long, M.D.
J. W. MacKenzie, Jr., M.D.
L. E. May, M.D.
G. E. Millard, M.D.
E. C. Mosier, M.D.
J. A. Read, M.D.
W. Z. Rundles, Sr., M.D.
S. R. Russell, M.D.
Sydney Scher, M.D.
J. M. Sheldon, M.D.
W. F. Strong, M.D.
C. K. Stroup, M.D.
E. J. Tallant, M.D.
H. C. Tellman, M.D.
E. J. Westfall, M.D.
C. L. Weston, M.D.
W. J. Zimmerman, M.D.
E. S. Oldham, M.D., *Advisor*
A. E. Schiller, M.D., *Advisor*

ANNUAL REPORT OF COMMITTEE ON TUBERCULOSIS CONTROL—1962-1963

The Tuberculosis Control Committee met on November 28, 1962, and on April 17, 1963.

1. The Committee continues to emphasize that tuberculosis remains a serious public health problem and that efforts should be intensified toward case finding and treatment.

2. Expansion of the Committee's functions to include other respiratory diseases is not recommended.

3. Efforts to publicize the role of the Private Practitioner in tuberculosis control have met with little success. We have been unsuccessful in being placed on the program of such organizations as the Michigan Chapter of the Association of General Practitioners. Efforts in this direction will be intensified.

4. The Committee developed Reference Cards of Diagnostic Criteria which are to be printed by the MTRDA and distributed to all Members of the State Society.

R. L. Rapport, M.D., *Chairman*
P. T. Chapman, M.D., *Vice Chairman*
M. B. Conover, M.D.
W. N. Davey, M.D.
L. F. Hayes, M.D.
J. L. Isbister, M.D.
A. H. Kempter, M.D.
E. J. Klopp, M.D.
D. A. Koch, M.D.
G. H. Phillips, M.D.
L. A. Pratt, M.D.
R. A. Rasmussen, M.D.
C. J. Stringer, M.D.
A. F. Turcke, M.D.

ANNUAL REPORT OF COMMITTEE ON VENEREAL DISEASE CONTROL—1962-1963

No meetings were held by the Committee on Venereal Disease Control for the year 1962-63.

R. L. Mainwaring, M.D., *Chairman*
M. W. Alcorn, M.D.
J. A. Cowan, M.D.
A. C. Curtis, M.D.
David Kahn, M.D.
S. D. Kobernick, M.D.
F. B. Levagood, M.D.
Benjamin Schwimmer, M.D.
Joan C. Stryker, M.D.
H. O. Thompson, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE TO WOMAN'S AUXILIARY—1962-1963

The Committee wishes to congratulate the officers and members of the Auxiliary on the success they have achieved in fulfilling the functions of their organization, and in the manner in which they have cooperated with and assisted the Michigan State Medical Society at all levels.

The Woman's Auxiliary is to be especially commended for its legislative work, its success in raising money for AMA-ERF, on the efficient methods in which it has communicated with regional and local units of the Auxiliary throughout the State, and for its diligence in meeting with these units.

The Committee has two suggestions to offer to the Woman's Auxiliary, the Michigan State Medical Society Councilors and local society officers:

(a) A few areas exist in this State in which the Woman's Auxiliary is not organized. The officers of the Auxiliary have expended great effort to organize these areas but have been unable to achieve success. The local Councilors and officers of the individual medical societies are urged to offer their cooperation.

(b) In view of the fact that some local auxiliaries are accentuating the social side of their organization, sometimes at the expense of the service areas within their scope, the Committee recommends that each of the local units of the Woman's Auxiliary review their program of activities and functions seeking the advice of their District Councilor and local county society officers, as well as the officers of the State Auxiliary to assure that the original purposes of the Woman's Auxiliary are properly fulfilled.

C. I. Owen, M.D., *Chairman*
R. V. Taylor, M.D., *Vice Chairman*
R. L. Himmelberger, M.D.
W. A. Hyland, M.D.
M. R. Weed, M.D.

Cites Challenges in Medical Communications

A concise presentation of today's problem of communications in the medical-health field was given at the 1962 annual meeting of the American Medical Writers' Association by James Hundley, M.D., Assistant Surgeon General. He summarized informed opinion about the medical-health communications crisis as follows:

1. Medical science has done much for humanity, but not nearly as much as could be achieved if communications were more adequate.

2. More so today than ever before, science fact and opinion must be communicated to the potential users of that information: the scientist, the practitioner, and the general public.

3. We have so much more to say to so many more than ever before that the tools we use for communicating appear inadequate, or even sometimes at odds with our purpose.

4. If the "information explosion continues, it may destroy *all* effective communication.

5. We can wait no longer; we must be bold; we *must* learn to use the knowledge, methods, and techniques that are at hand, and waiting, to solve this problem.

6. However, in our rush to embrace the glories of automation, let us not slight the need for improvements in traditional methods of communication—for example, more and better qualified evaluators, or "synthesizers," who will help us translate *papers* into *useful information*, more rapid and more effective publication of research results, better libraries, and more extensive person-to-person communications.

MICHIGAN DEPARTMENT OF HEALTH
ALBERT E. HEUSTIS M.D., State Health Commissioner

Rabies—Laboratory Specimens

Diagnosis

The Michigan Department of Health Laboratories has used the Fluorescent Antibody Technique in Rabies diagnosis unofficially for the past one and one-half years. This experience has led us to conclude that its reliability is on a par with the mouse inoculation technique.

In order to expedite the results of rabies diagnostic procedures, effective July 1, 1963, specimens from the following animals will undergo direct examinations and FA techniques only:

(A) Rodents kept as domestic pets, such as white mice, hamsters, rabbits, guinea pigs, white rats.
(B) Wild rodents, specifically rats, squirrels, and field mice.

Direct examination and animal inoculation tests will be used in all other species submitted for rabies examination. Conventional tests will be supplemented by FA technique in instances where direct or animal inoculation results are equivocal.

FA tests will be conducted on Tuesday and Friday of each week and results will be reported the day of the test.

Limitations

Increased demands for examinations for rabies made to the Division of Laboratories of the Michigan Department of Health make it necessary to require much closer medical screening of specimens submitted. Only specimens which meet the following criteria will be accepted for rabies examinations:

1. Human exposure as determined by a physician.
2. Animal exposure as determined by a physician or veterinarian, and then examination will be made only when necessary to establish a legal basis for destruction of the exposed animal.
3. Those specimens of special interest to the Department of Conservation.

Animal heads only will be accepted. Do not send or bring an entire carcass.

Shipment of Animal Heads to Laboratories

All shipments of animal heads to laboratories should be made according to the regulations printed in the booklet "Michigan Regulations for the Control of Communicable Disease." Whenever possible, a specimen to be examined for rabies should be delivered directly to the Michigan Department of Health, Division of Laboratories, 3500 North Logan Street, Lansing, Michigan.

The following information shall accompany all heads sent for examination of rabies: name of sender, address of sender, owner's name, and address, animal and breed, date of death, whether killed by an officer, shot or injected, clinical diagnosis, and any exposure (persons bitten). This information should accompany the head either in a letter or on Form F292, Michigan Department of Health. Copies of this form may be obtained from the Division of Laboratories upon request.

Medical Self Help

Michigan leads the nation in the number of persons who have received training in emergency medical self-help procedures.

During the first six months of the year a total of 9,928 persons completed the 12-class course which includes instruction in such subjects as shock, bleeding and bandaging, artificial respiration, transportation of the sick and injured, infant and child care, hygiene, sanitation, food and water, and emergency childbirth procedures.

The courses are sponsored by local health departments or civil defense offices with cooperation of local medical societies. Most of the persons who have been trained so far are adults, however, emphasis is now being placed on the training of high school students, and many schools are incorporating the classes into their curriculum.

Thirteen of Ingham County's fourteen high school districts have indicated that medical self-help will be

(Continued on page 816)

Sustained high-level protection in peptic ulcer



all day



all night



with b.i.d. dosage

PRO-BANTHĪNE P.A.®

Brand of PROPANTHELINE Bromide

Prolonged-Acting Tablets—30 mg.

Pro-Banthīne P.A. provides the full anticholinergic benefit of Pro-Banthīne® plus the greater convenience and more consistent therapeutic effect of a long-acting dosage form.

Asher[1] has summarized the advantages of prolonged-action dosage forms: "First, they should be of great value in the suppression of night acid secretion in the ulcer patient. Also, in the ulcer patient, with high acid secretion during the day these drugs should be of help when used with regular doses of shorter-acting anticholinergic agents. A third application is in the chronic treatment of certain patients whose tendency to recurrent ulcer has been established."

Pro-Banthīne P.A. offers consistent, sustained anticholinergic effects for more consistent suppression of acid secretion and motility on simple twice or thrice daily dosage in most patients.

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Suggested Adult Dosage:
One tablet at bedtime and one in the morning, supplemented, if necessary, by additional tablets of Pro-Banthīne P.A. or standard Pro-Banthīne to meet individual requirements.

Pro-Banthīne P.A.
is supplied as capsule-shaped, peach-colored tablets of 30 mg. each.

Contraindications:
Glaucoma; severe cardiac disease.

Possible Side Actions:
Xerostomia, mydriasis and, occasionally, hesitancy in urination. Theoretically, a curare-like action may occur.

1. Asher, L. M.: The Choice of Anticholinergic Drugs in the Treatment of Functional Digestive Diseases, Amer. J. Dig. Dis. 4:260-275 (April) 1959.

CAMP

SACRO-ILIAC SUPPORTS

aid in relieving chronic spine and pelvic strain caused by faulty body mechanics

Many practicing physicians have found Camp sacro-iliac supports play an important part in the conservative treatment of low back syndrome. Camp's adjustment feature is scientifically designed to encircle the bony pelvis and take effect between the iliac crest and greater trochanter. Lacers running through buckles double and redouble the power to bring the lower portion of the support about the pelvis. This pelvic stabilization helps to rest and support the locomotor structures of the body, secures relief from pain and muscle spasm and tends to restore the physiologic curves of the spine. Provision is made for sacro-iliac pads to further lessen rotary movements of the sacro-iliac joints, when so desired. The supports illustrated below are two in a series of Camp orthopedic garments designed to help relieve one of the most common complaints confronting physicians —low back pain.

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"Keep Politics Out of Health"

By Ladd Plumley, *President, United States Chamber of Commerce*

"Make no mistake: those who would politicalize the health problem of our aged feel themselves stronger than ever before, more hopeful of victory. Their campaign to impose medicare upon the American people will be carried forward with all of the resources, all of the political ingenuity, and all of the promotional pressure—paid for with your hard earned tax dollars—that the Administration can bring to bear. Twice rebuffed, they will hit back harder than ever.

"Those who actively seek the Social Security approach are counting on our becoming so battle weary that we will quit fighting for what we believe is best for all Americans.

"One of their leaders has summed up this attitude in unmistakable language:

* * *

"IF NOT in '62 THEN we will pass it in 1963, and if not then we will pass it in 1964. And if we don't do it then—when we elect a President and a Congress in 1964—we will certainly pass it in 1965. If we do not rise to meet each of these challenges, we will lose the war.

"The compulsory Medicare Bill of 1962 was a callous, clumsy, inequitable attempt to solve a limited problem with a broad-scale approach. It was brain surgery with a meat axe. It was callous because we already have a majority of people over 65 covered by private insurance plans, 12 per cent protected by public assistance, and a law on the books to provide care for the remainder who need it. Nowhere have I seen or heard of the Administration urging that the states rapidly implement this existing law.

As a matter of cold fact, Administration spokesmen are busy deriding the Kerr-Mills Act as insufficient, while tens of thousands of the aged, in their states—in their districts—for whom they profess public sympathy, but practice private apathy, are without this medical care protection.

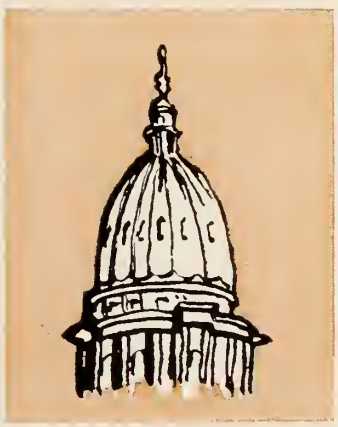
Let's begin with a statement of the problem as the Social Security proponents say it exists.

First, the aged spend, on the average, about twice as much on medical care as do younger persons. This statement is true.

Second, since most aged persons are no longer working, their money incomes, on the average, are only about half as large. This statement is true.

Third, the cost of medical care is high and rising. This statement is true.

Fourth, most aged men and women are unable to finance their own health care costs. This statement is false.



THE PROPONENTS OF FEDERAL medicare say the only solution is to increase Social Security taxes on every working person and on his employer. This money would be used currently to pay hospitals, nursing homes, and home health agencies rendering services to aged persons. This "only solution" statement is false, because the Administration proposal is not the only solution. Private enterprise will do the job—provided we do not let it fall into political hands, provided we keep politics out of health and federal surveillance out of sickness.

* * *

"THE FACT THAT PRIVATE enterprise can do the job is the first major reason why this medicare program is both unnecessary and undesirable. This land was made great by private business—not by the socialistic schemes of bureaucrats.

"This brings me to the second major reason why there is no need for federal medicare. In 1960, Congress passed what has come to be known as the Kerr-Mills program of "Medical Assistance for the Aged." It is designed to help those over 65 who can meet their everyday living expenses but just can't meet some or possibly all of their medical expenses.

"There is yet a third reason why the Social Security approach is not needed, and that concerns a current myth about the economic status of our older citizens —the myth that many of our over-65 people are poverty stricken.

"On a family basis, we find that many of the aged have at least a modest money income. In 1960, half of the 6.2 million families headed by persons over 65 had money incomes of $2,900 or more, and, where the head of the families had incomes of over $5,200 a year. A surprising number of our 'senior citizens' continue to work after they reach 65. In fact, about 3.1 million men and women over age 65 were job holders as recently as last August.

"While it is true that most of our aged are no longer working, it is equally true that they no longer have the costly responsibilities of younger people who are working. Their children are grown, they no longer have to worry about clothing, feeding, housing, and educating them, and they pay reduced federal income and—if over 65—no Social Security taxes.

"More importantly, many have larger assets than do younger people. The 1960 Survey of Consumer Finances conducted by the University of Michigan reported that 87 per cent of the families headed by persons 65 and over had some assets, and half of those had total assets of $9,400 or more. Included in these assets is the home, a very important item. Government figures show that 65 to 70 per cent of our over-65 families own their homes, completely paid for. In contrast, the survey found that only half the families headed by persons 35 to 44 years old had assets of $6,000 or more, and in the under-35 group only half had total assets of $900 or more. And practically all of them were struggling to meet mortgage payments and to raise their families.

* * *

"LET'S ALL REMEMBER that it wasn't the government that made this country economically strong. It was a people gifted with courage and ability to do for themselves. It's a strange irony that a people who, just a month ago, faced calmly and steadfastly the imminent peril of nuclear war are being told that they can't take care of themselves.

"The United States is the only country where there still flourishes the opportunity to experiment, to innovate, and to develop voluntary solutions in the medical care field.

"Let's keep it that way.

"Let's keep politics out of health, federal surveillance out of sickness."

* * *

Legislating Against the Patient

(New Medical Materia, February, 1963.)

No one will deny that a strong Food and Drug Act is necessary to protect the public. But the intended (FDA) regulations will increase the cost of screening new drugs, will limit the number of new drugs approved, and may prevent many excellent medications from reaching the doctor. The . . . legislation will adversely affect the very person the law was meant to protect—the patient. W. D. PAUL, M.D.

Medical Self Help

(Continued from page 812)

taught beginning in the fall. A number of schools throughout the state are offering it as a credit course.

Every state in the union has a medical self-help training program in operation. The goal established by the Public Health Service is to train at least one member of every family in the country. To do this, a compact training kit has been designed and supplied in quantity to every state. There are approximately 640 of these kits being used in Michigan.

For the most part, lay persons have been conducting the courses in Michigan, although in some communities doctors, nurses, and sanitarians have participated in the course presentation.

Last year, the first year of the program, when only about 160 kits were available, approximately 4,500 persons were trained.



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The outstanding effectiveness and record of safety with which 'Miltown' (meprobamate) relieves anxiety and anxious depression has been clinically authenticated time and again during the past eight years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more than any other tranquilizer in the world.

Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.

Usual dosage: 1 or 2 400 mg. tablets t.i.d. **Supplied:** 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50.

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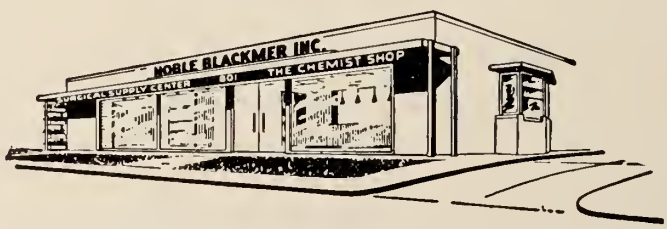
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Practically standard treatment, now, for perforated ulcer. Why is Maalox included? Antacid therapy *must* continue long after the wound has healed, and patients started on Maalox tend to stay on Maalox. It tastes good; it's effective and will not cause constipation—three important reasons for Maalox over the long haul. Some physicians, we are told, order Maalox routinely for hospital patients on drugs which could irritate. They feel it reduces the likelihood of gastric discomfort. Supplied: Suspension; Tablets No. 1; Tablets No. 2. (Each Maalox No. 1 Tablet is equivalent to 1 teaspoonful and each Maalox No. 2 Tablet is equivalent to 2 teaspoonfuls of Suspension.)



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In dealing with the chronic stress of arthritis the physician often faces the problem of nutritional imbalance. High potency B and C supplementation is needed for rapid replenishment of tissue stores of these water-soluble vitamins. STRESSCAPS meet this need and help support the natural metabolic defenses in the disease.

FOR PROFESSIONAL

RECOMMENDATION ONLY

Each capsule contains: Vitamin B_1 (Thiamine Mononitrate)...10 mg. / Vitamin B_2 (Riboflavin)...10 mg. / Niacinamide... 100 mg. / Vitamin C (Ascorbic Acid)...300 mg. / Vitamin B_6 (Pyridoxine HCl)...2 mg. / Vitamin B_{12} Crystalline... 4 mcgm. / Calcium Pantothenate...20 mg. Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100.

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Add Public Members To Blue Cross Board

The composition of the Michigan Blue Cross board of directors is now 19 public members, 19 hospital members and four medical members—and will be altered further at the March, 1964, annual meeting, when three more public members will replace two medical members and one hospital member.

This action to increase public membership stems from Blue Cross board action in January, recommending that the bylaws be amended to provide a public majority by March, 1964.

The men newly elected as public members are: Albert Schaller, publisher of the *Petoskey News Review*; Edward Fisher, president of the Bank of Lenawee, Adrian; Robert T. Herkner of the law firm of Herkner, Smits, Miskill and Johnson of Benton Harbor; and John D. Morrison, retired certified public accountant from Marquette.

In addition, Alex Fuller, vice president of the Wayne County AFL-CIO, was elected a member to fill out the unexpired term of Al Barbour, president of the Wayne County AFL-CIO, who resigned.

Five public members who were re-elected are: Harry R. Davidson, superintendent of schools of Battle Creek; Roy L. Jacobus, manager of the insurance department of Ford Motor Company; Wayne Stettbacher, general manager of the Employers Association of Detroit; Rev. John A. Trese, director of Catholic Social Services for Oakland, Washtenaw and Monroe Counties; and Clayton F. Jennings, partner in the law firm of Jennings, Younger, Parsons, Keyworth and Warren in Lansing.

Newly elected trustees representing hospitals to fill vacancies are: Max J. Zivian, trustee on the board of Sinai Hospital, Detroit; Ralph Lingberg, D.O., administrator of Detroit Osteopathic Hospital; Donald E. Wallenbach, superintendent of Hurley Hospital in Flint; and Carl F. Schilling, a certified public accountant and a member of the Bay City General Hospital's board.

The Blue Cross Board also re-elected for one-year terms the following board and administrative officers: Chairman of the Board—John W. Paynter, financial vice president and treasurer of the J. L. Hudson Company; Vice Chairman of the Board—George E. Cartmill, director of Harper Hospital; Vice Chairman and Treasurer—Ralph E. Phelps, assistant secretary of the S. S. Kresge Company; President and Secretary—Wm. S. McNary, chief administrative officer of Michigan Blue Cross since 1947; Assistant Secretary—Hazel Kennedy.



UP Medical Society Has Fine Program

The Upper Peninsula Medical Society held its 68th Annual Meeting at the Objibway and Park Hotels in Sault Ste. Marie, June 28-29, 1963, with an attendance of 103 Upper Peninsula physicians and their wives. An excellent program under the Presidency of C. H. Clausen, M.D., of Sault Ste. Marie was presented, including Michigan guest speakers William M. Mikkelsen, M.D., Ann Arbor; M. Berkas, M.D., Dearborn; Richard D. Judge, M.D., Ann Arbor; Edward A. Kahn, M.D., Ann Arbor; Leo A. Lindquist, M.D., Marquette; Clifford D. Benson, M.D., Detroit; and Richard L. Rapport, M.D., Flint, on the program.

Speakers representing the Michigan State Medical Society were C. I. Owen, M.D., of Detroit, and Orlen J. Johnson, M.D., of Bay City, President and President-Elect respectively. Sidney Adler, M.D., Detroit, President of Michigan Medical Service, presented a report on the court decision re Blue Shield.

The 1964 Upper Peninsula Medical Society meeting will be held in Houghton next June under the Presidency of Andrew Roche, M.D., of Houghton.

Doctor Heustis Reappointed State Health Commissioner

Governor Romney in July reappointed Albert E. Heustis to another four-year term as State Health Commissioner. In making the announcement, Governor Romney said, "Dr. Heustis is known for his long experience in the field of health, and Michigan stands to gain much by his further service." First appointed in 1948 by Former Governor Sigler, Doctor Heustis was reappointed by Former Governors Williams and Swainson.

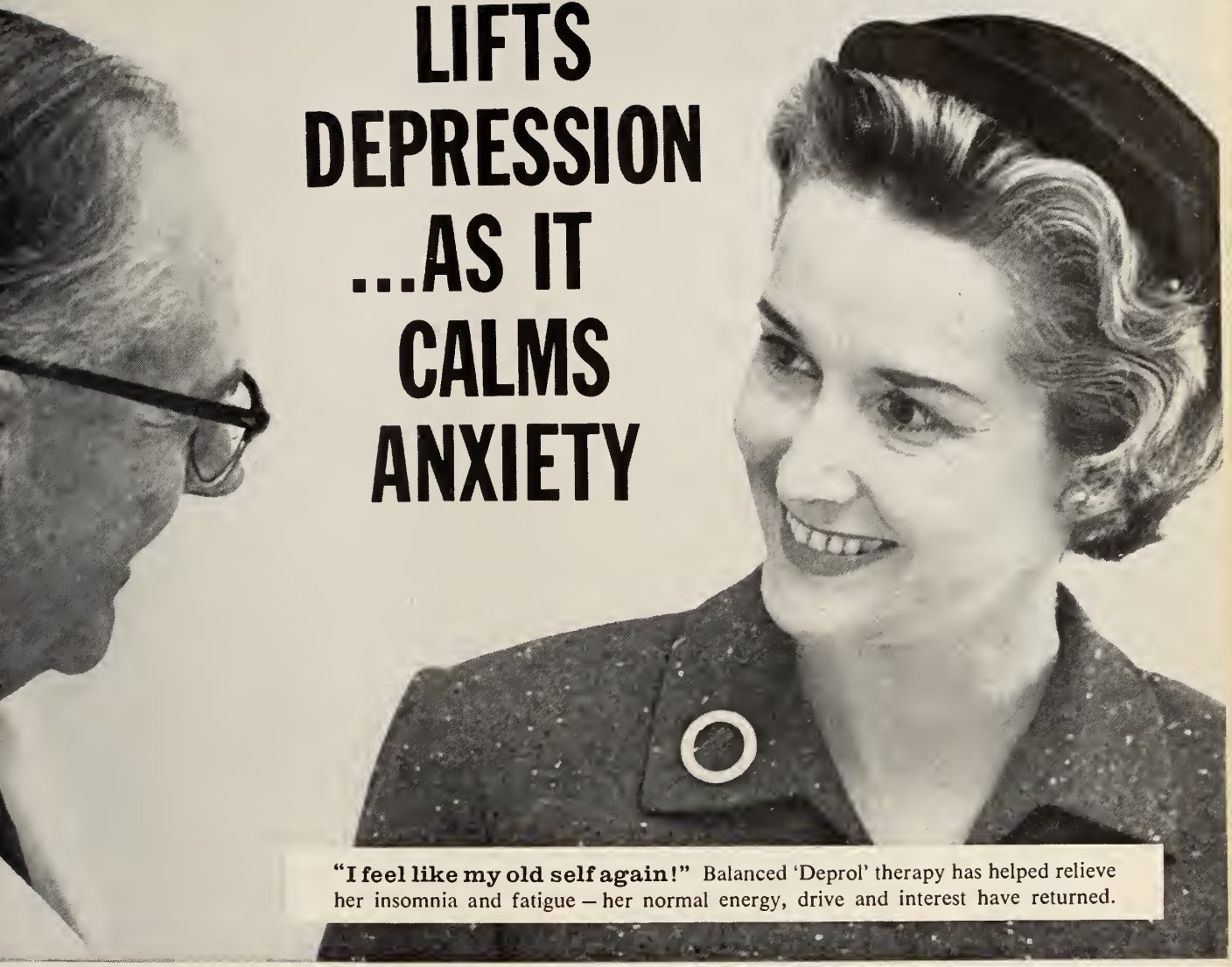
Senate confirmation is required. Under the new appointment, Doctor Heustis would receive $22,500 annually, an increase from the former $19,000.



"Man in His Struggle for Health"

This mural was donated by Wayne State University's medical class of 1962 and was dedicated June 9, 1963, in the basic sciences building. "Man in His Struggle for Health" is the theme of the mural created by Charles Kohl, Detroit, who was selected from more than 30 artists who entered the competition. The mural displays man's development from infancy to old age. Prominent and centered in the 18 by 6 mural is a pair of eyes symbolizing man's recognition of his own role in healthful living and achieving insight into his own problems.

LIFTS DEPRESSION ...AS IT CALMS ANXIETY



"I feel like my old self again!" Balanced 'Deprol' therapy has helped relieve her insomnia and fatigue – her normal energy, drive and interest have returned.

Brightens mood...relaxes tension

Energizers may stimulate the depressed patient, but they often aggravate anxiety and insomnia. Tranquilizers may help the anxious patient, but they often deepen depression. 'Deprol' avoids these "seesaw" effects; it relieves both anxiety and depression. Moreover, it does not cause liver damage, psychotic reactions or changes in sexual function.

Slight drowsiness and, rarely, allergic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.

Usual Dosage: 1 tablet q.i.d. May be increased gradually, as needed, to 3 tablets q.i.d.; with establishment of relief, may be reduced gradually to maintenance levels.

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Select WSU Chairmen For Medical School

Three new department chairmen who will fill vacancies in the Wayne State University College of Medicine have been announced by Gordon H. Scott, M.D., dean of the college and vice president for medical college development.

Ray K. Brown, M.D., Albany, N. Y., has been named chairman of the department of physiological chemistry, replacing Arthur H. Smith, M.D., Detroit, who retired July 1 after serving in the department since 1937. Doctor Brown was previously with the New York State Department of Health from 1953-63 and with Albany Medical College from 1954-63.

Herbert Pederson, M.D., Dearborn, the new chairman of the department of orthopedic surgery, succeeds Angus E. Goetz, M.D., Grosse Pointe, who asked to be relieved of the chairmanship after serving since 1946. Doctor Pederson has been a member of the department since 1928.

Jan Beekhuis, M.D., Grosse Pointe, will be the chairman of the department of otolaryngology, replacing James E. Croushore, M.D., Birmingham. Doctor Croushore also asked to be relieved of his chairmanship which he has held since 1953. He had served as acting chairman from 1949-53. Doctor Beekhuis has been on the staff in otolaryngology since 1957.

Both Doctors Goetz and Croushore will continue their positions as clinical professors.

U-M Selects 200 From 1,000 Applicants

Two hundred students, including 12 women, have been selected by the University of Michigan Medical School to enter training in September as the class of 1967.

C. J. Tupper, M.D., associate dean, reports the 200 were admitted from approximately 1,000 applicants. Of those selected, 76 did their undergraduate work at the University of Michigan.

Other schools in Michigan contributed students to the U-M Medical School as follows: Wayne State University, 23; Michigan State University, 13; the University of Detroit, 8; Calvin College, 7; Albion College, 6; Western Michigan University, 5; Eastern Michigan University, 4; Kalamazoo College, 3; Alma College, 2; and Olivet College, Ferris Institute, Central Michigan University, General Motors Institute, and Highland Park Junior College, one each.

Say you saw it in the Journal of the Michigan State Medical Society

AMA Takes Important Action on Many Matters

The 112th Annual Meeting of the American Medical Association, held June 16-20, 1963, in Atlantic City, covered many subjects in both the scientific and economic fields.

Most important among the latter in the House of Delegates actions: The Enlargement of the Board of Trustees; Rearrangement of the Sections and intensive scientific programs; Compensation of interns and residents; Physicians pension plan; Social Security for Physicians; Report on the Study of Tobacco and Disease; and establishment of a new Institute for Biomedical Research without recourse to government subsidy for it.

* * *

A HIGHLIGHT AT THE Annual Meeting was the announcement that the American Medical Association will establish and operate a new Institute for Biomedical Research which will bring together a group of eminent scientists in many different disciplines of the biological sciences to seek an understanding of molecular events within the cell. The program will be dedicated to pure, basic, non-disease oriented research—and as such will not render medical service to patients and will not conduct a graduate training program leading to a degree. The institute will be housed in the new addition to the American Medical Association headquarters building in Chicago.

SEVENTY-ONE RESOLUTIONS were sent to reference committees for study and recommendation.

Following are brief digests of House of Delegates action on various matters:

MSMS Well Represented

This article contains excerpts from a comprehensive report about the 1963 Annual Meeting of the AMA House of Delegates which will be given to each member of the MSMS House of Delegates in September. The excellent, detailed report was developd by Wm. A. Hyland, M.D., Grand Rapids, Chairman of the Michigan delegation.

MSMS delegates and alternates include: Sidney Adler, M.D.; B. M. Harris, M.D.; J. R. Heidenreich, M.D.; Chairman W. A. Hyland, M.D.; O. J. Johnson, M.D.; L. R. Leader, M.D.; E. E. Martmer, M.D.; C. I. Owen, M.D.; A. H. Price, M.D.; R. E. Rice, Jr., M.D., and J. M. Wellman, M.D.



Residents and Interns

The House disapproved the report of the Council on Medical Service and the Council on Medical Education and Hospitals on Compensation of the House Officers, substituting the following which was adopted.

"We therefore recommend that in view of the overwhelming opposition to the basic proposal contained in the report of the Council on Medical Service and the Council on Medical Education and Hospitals, the American Medical Association record itself as opposed to any system or program by which any part of an intern's or resident's salary is paid out of fees collected by the attending physician or out of fees collected under any type of medical surgical insurance coverage."

The House, while declaring that the joint council report "represents a well-intentioned effort to find a solution to a most difficult, if not impossible, problem," recommended that any future proposals on the compensation of house officers be thoroughly studied by the Law Department and Judicial Council before submission to the House of Delegates.

Relating to the controversial "25% rule", the House approved a revision of the Essentials of an Approved Internship which deletes the requirement of any stated proportion of foreign medical graduates and graduates of American and Canadian medical schools as an essential feature of any internship program.

Nursing Homes

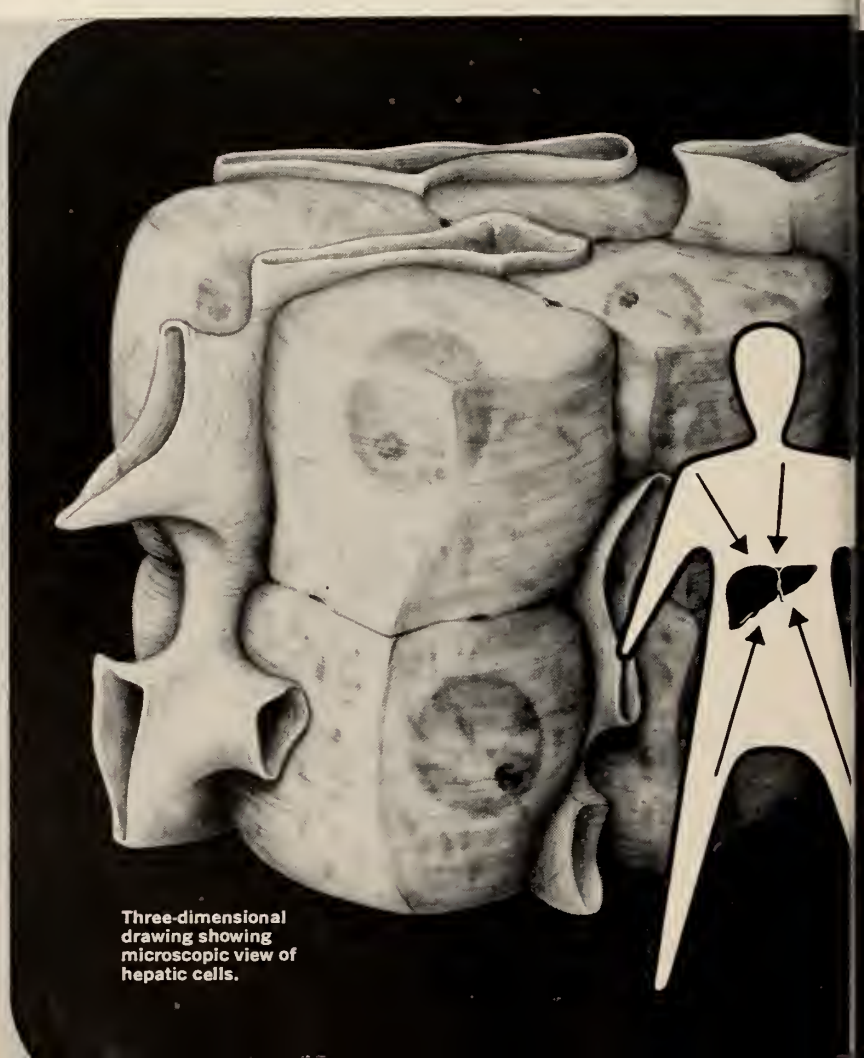
A committee was appointed by the Board consisting of five physicians and four members of the American Nursing Home Association to work out plans for accreditation of Nursing Homes. This was supported by House action.

Board of Trustees

In adopting the Ad Hoc Committee report to enlarge the Board from eleven to fifteen members by the addition of the immediate past president for one year and three elected members to the Board for terms of three years with the privilege and possibility of being elected for two more terms of three years each (totaling nine years) the House voted to amend the constitution to comply with the recommendation. To facilitate this matter the Constitution and Bylaws Committee caused an amendment to be laid on the table at the Los Angeles meeting in November, to comply with the articles of the constitution for six month lay over. This made possible the election of the new members to the Board at this session.

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Liberty Amendment

The "Liberty Amendment," a proposed change in the U. S. Constitution that would, among other things, prevent the Government from competing with private enterprise and do away with the Federal income tax. The American Medical Association bodies for years have refused to consider taking a stand on the proposal, which has been approved by five southern and western states, on the grounds that it was not a medical matter. But last November a committee decided that if so many American Medical Association members were interested in it, then it is "properly within the purview" of the organization. The Council report was discussed.

Physicians Pension Plan

The House approved establishment of a physicians pension plan under the provisions of the Self Employed Individuals Retirement Act of 1962; it also urged the Board to make every effort to begin operation of the plan before the end of 1963 in order for physicians to participate this year.

Tobacco and Disease

The House agreed with a Board of Trustees report which stated that the American Medical Association should defer any definitive statement regarding the relationship of tobacco and disease. The report pointed out that the American Medical Association is continuing its study of this important subject and is merely deferring any public pronouncement pending the availability of more information, including whatever may come from the study of a committee appointed by the United State Public Health Service. In taking this action, the House declared that extensive research is still necessary for the complete answers on the cause and effect of many toxins, including tobacco. However, the House said that the American Medical Association "has a duty to point out the effects on the young of the use of toxic materials, including tobacco, and these facts should be disseminated, particularly in our schools.

Medicare

In regard to Medicare, the House again was in the mood to urge all to aid the positive working of the Mills-Kerr Bill in each state. The feeling was that this form of aid was making progress in nearly every area and soon could be the nearest to the complete answer. Suggestions of any form of compromise other than that which would enhance the Mills-Kerr Bill were frowned upon by the Legislative Committee and its Washington advisors at this time.

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Social Security for Physicians

A resolution was presented by the New York delegation requesting the American Medical Association to poll its members as to their feelings for or against social security and to make the result public. In the Reference Committee hearing the evidence was all against this procedure. When it reached the House the recommendation not to so do was overwhelmingly sustained. The Michigan poll of several months previously was approximately 3 to 2 for social security for physicians. The Speaker of the House of Delegates of the American Medical Association was so notified of our result which was the directive of the Michigan State Medical Society House of Delegates at the 1962 session. The Michigan group voted for the poll requested by New York, but we were with the very slim minority group.

Miscellaneous Actions

In considering many resolutions and reports, the House also:

- Recommended that local medical societies in the vicinity of schools assume the responsibility of establishing and maintaining clear lines of communication with medical students.
- Took a position opposing the student loan provisions of the Health Professions Educational Assistance Act of 1963.
- Disapproves a Judicial Council opinion on the dispensing of glasses by ophthalmologists and reaffirmed the Council's interpretation of Section 7 of the Principles of Medical Ethics, as reported in the November 15, 1958, issue of the Journal of the American Medical Association.
- Urged all state and county medical societies to adopt and activate all phases of "Operation Hometown".
- Disapproved of federal funds for staffing new community mental health centers.
- Approved a Judicial Council opinion on physician ownership of drugstores, drug repackaging houses and pharmaceutical companies.
- Approved of American Medical Association participation in the recent formation of a Joint Commission on Medicine and Pharmacy.
- Commended the American Farm Bureau for its leadership in opposing unwarranted government interference and regulation.
- Adopted the recommendations of the Committee to Study the Joint Commission on the Accreditation of Hospitals and suggested that the committee's report be distributed to constituent and component societies and hospital chiefs of staff.
- Recommended that all American Medical Association members and associate groups support the national tuberculin testing campaign proposed by the American School Health Association.

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Election of Officers

N. A. Welch, M.D., Boston, was elected president-elect. Other officers elected are: D. F. Ward, M.D., of Dubuque, Iowa, vice president; Milford O. Rouse, M.D., Dallas, Texas, speaker of the House and Walter C. Bornemeier, M.D., Chicago, vice speaker.

ALL THE MICHIGAN Delegates and Alternates attended various Reference Committee meetings with most of them taking part in the discussions. Drs. Owen and Heidenreich served on Reference Committees.

The Chairman wishes to express his sincere appreciation to the Delegates, Alternates, Officers and Executive Staff for their advice and counsel at all times and to the Michigan State Medical Society House of Delegates for allowing us to represent the organization in the American Medical Association House of Delegates.

* * *

Detroit Is Host

The District V meeting of the American College of Obstetricians and Gynecologists will be held in Detroit at the Statler Hilton Hotel, October 24-25-26, 1963.

Many Doctors Receive Honors

RECEIVES AWARD—Lorenzo R. Nelson, M.D., Idlewild, was recently honored by Lake County residents with an award, which cites him "for constantly being on call and willingly available to all the ill who need him, those who paid him for his services and those who could not." Doctor Nelson has practiced in Lake County since 1946.

* * *

PRESIDENT—Maurice Tatelman, M.D., Detroit, is the new president of the Faculty Senate of the Wayne State University College of Medicine. He succeeds A. J. Vorwald, M.D.

* * *

ELECTED—Edward H. Rodda, M.D., Bay City, was elected a member of the board of directors at the recent meeting of the Michigan Association for Emotionally Disturbed Children. William D. Harrelson, M.D., Kalamazoo, completed his term as president of the organization.

* * *

CITED—John Morris Dorsey, M.D., Highland Park, was recently honored by the Merrill-Palmer Institute for his "lifetime of accomplishment in the field of medicine, psychiatry, and mental health—as practitioner, teacher and administrator."

* * *

HONORED—St. Luke's Hospital staff at Saginaw recently gave a Distinguished Physician Award to Robert F. Powers, M.D. Its award for contributing the most to intern education went to Walker C. Averill, III, M.D.

* * *

SELECTED BY AMA—Ralph Blocksma, M.D., Grand Rapids, was appointed by the American Medical Association as official representative to the First International Congress of Christian Physicians, Amsterdam, Netherlands, July 15-18.

* * *

CITED—R. A. Tearnan, M.D., director of the Alger-Schoolcraft Health Department and a practicing physician and surgeon for 50 years, was honored at the recent meeting of the Upper Peninsula Public Health Organization at Munising. He has practiced 34 years in Munising, where he has maintained an active interest in athletics and community affairs.

* * *

SPEAKER—Richard J. Bing, M.D., Birmingham, spoke at the Second Annual Symposium of the American Heart Association and at the American Medical Association in Atlantic City on circulation and metabolism in heart disease.



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SAMA WINNER—Walter B. Forman, a senior at Wayne State University College, won the recent SAMA-Mead Johnson Scientific Forum Award for his paper, "Cellular Site for Fibrinogen Synthesis." He delivered his paper at the 13th annual meeting of the Student American Medical Association, and also at the June 1963 AMA convention in Atlantic City. In addition, he received a $500 check, a plaque and an expense-paid trip to both the SAMA and AMA meetings.

* * *

LEADER—William H. Kelly, M.D., Lansing, assistant director of the Michigan Mental Health and administrator of the community services division, is the new president of the Michigan Society of Neurology and Psychiatry. He had formerly served as treasurer of the professional organization which has 483 members.

* * *

NEW POSITION—Sumner H. Whittier, former executive director of the Michigan Blue Shield medical insurance program, is the new head of the National Society for Crippled Children and Adults. The agency is a $20 million nationwide federation of voluntary welfare agencies with headquarters in Chicago.

* * *

JOINS U-M—Luther Cristman, president of the Michigan Nurses Association, will begin duties this fall as associate professor of nursing at the University of Michigan. He is leaving the Michigan Department of Mental Health after seven years as nursing consultant.

* * *

AID OFFERED—Medical students and others whose major educational objective is related to the field of rehabilitation for the cerebral palsied and other handicapped persons may be eligible for financial assistance from the United Cerebral Palsy Association of Michigan. For information, write to the Association, 215 West First Street, Flint 3.

* * *

WINS RIBBON—An oil painting exhibited by W. C. Behen, M.D., Lansing, at the American Medical Association convention in Atlantic City received a ribbon and was sent to New York with other prize-winners for further exhibits during October. Doctor Behen exhibited four oils as part of the annual show of the American Physicians Art Association.

* * *

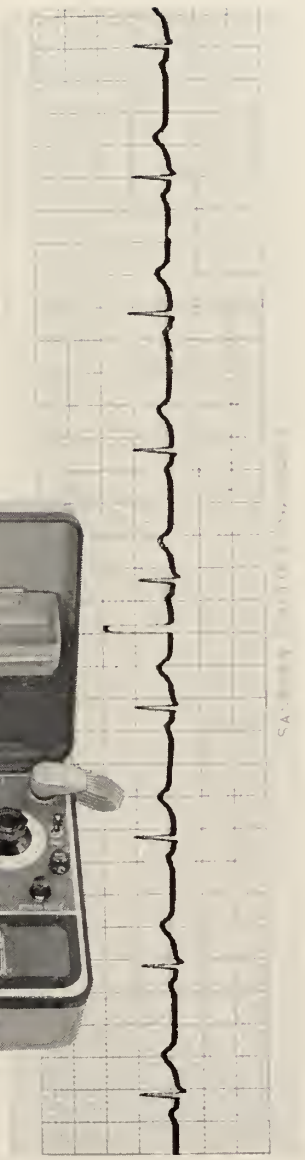
MORE PLACEMENTS—Recent placements by the M.D. Placement Service of the Michigan Health Council included the following: Dennis Burke, M.D. (Saline); Delmer E. Garrison, M.D. (Saline); Benjamin A. Passos, M.D. (Charlotte); Keith L. Curtis, M.D. (Charlotte); Daniel D. Joseph, M.D. (Charlotte); Thomas B. Hill, M.D. (East Lansing, Michigan State University Student Health Service); Terry E. Burge, M.D. (Holt); Edmond Henelt, M.D. (Hillsdale); Charles W. Hirschler, M.D. (U. of M. Health Service, Ann Arbor); Carl O. Sonnemann, M.D. (East Lansing, MSU Student Health Service); and Forrest C. Clore, M.D. (Lansing).

* * *

CERTIFIED—The American Board of Obstetrics and Gynecology reports that the following Michigan doctors have been certified as Diplomates: David G. Anderson, M.D., Ann

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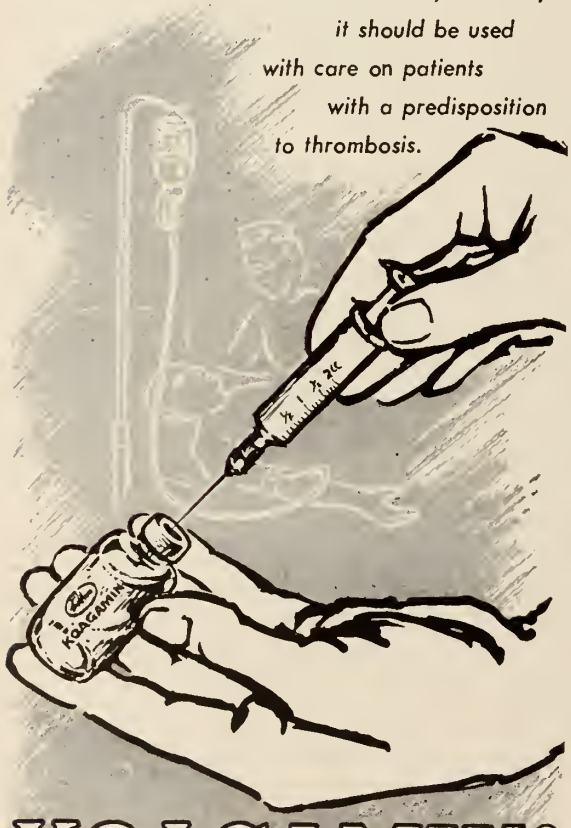


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* * *

WRITERS ASSOCIATION MEETS—On May 15, the Michigan Section of the American Medical Writers Association had a formal meeting in Ann Arbor, under the new President, Howard Ross, M.D. There was a formal program extending throughout the forenoon beginning at 9 o'clock with special papers by about five different authors including medical writing and historical affairs, medical writing on various topics.

At 12:30, the program had been completed and a prepared lunch with Dean Hubbard of the University of Michigan Medical School talked to us, after which we adjourned to the medical science building where the program was already in session. Two students presented reports of research work and this was followed by a discussion led by the late Wilfrid Haughey, M.D., Editor of THE JOURNAL of the Michigan State Medical Society.

Michigan Authors

Meyer O. Cantor, M.D., M.S., F.A.C.S., Detroit, "Clinical Application of Intestinal Intubation," *The American Journal of Gastroenterology*, May, 1963.

Steven J. Figiel, M.D., Detroit, "The Role of the Radiologist in Intestinal Obstruction," *The American Journal of Gastroenterology*, May, 1963.

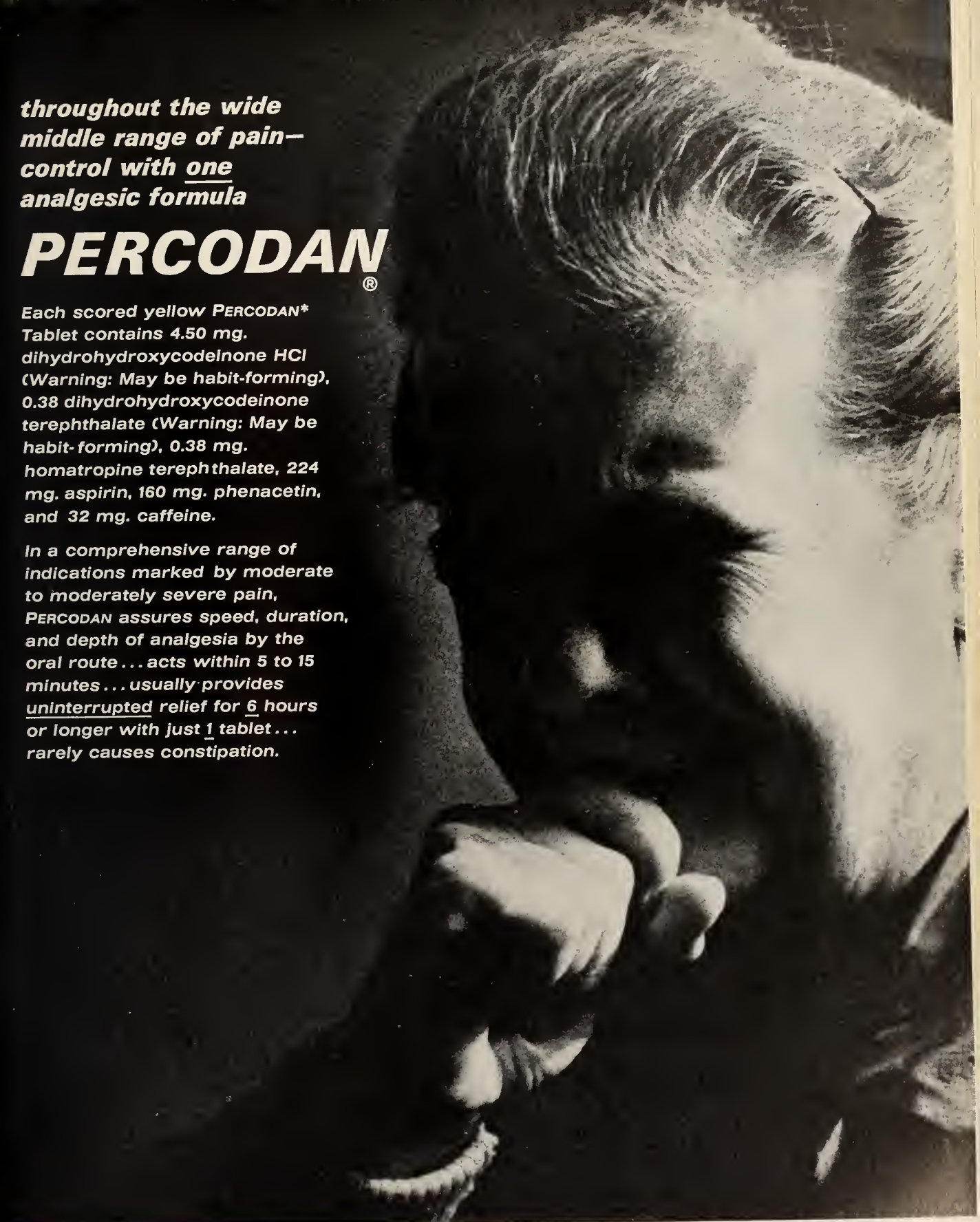
Meyer O. Cantor, M.D., Detroit, "The Obstructed Large and Small Bowel," *The American Journal of Gastroenterology*, May, 1963.

Robert E. L. Berry, M.D., Ann Arbor, "Parenteral Fluids and Intestinal Obstruction," *The American Journal of Gastroenterology*, May, 1963.

Jean B. Rosenbaum, M.D., Detroit, "The Integration of 'Ole Miss,'" *Bulletin of The Philadelphia Association for Psychoanalysis*, March, 1963.

P. L. Lowinger, M.D., R. M. Knox, M.D., and **C. E. Schorer, M.D.,** Detroit, "Personality Development in Identical Twins," *Archives of General Psychiatry*, 8:509-517, 1963.

J. T. Hayes, M.D., and **H. P. Gross, M.D.,** Ann Arbor, "Orthopedic Implications of Myelodysplasia," *Journal of American Medical Association*, June 8, 1963.



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IN MEMORIAM

WILFRID H. HAUGHEY

Wilfrid H. Haughey, M.D., editor of THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY for the past 22 years and one of the founders of Michigan Medical Service, died July 12, 1963, in Battle Creek.



Doctor Haughey, who was 82 years old, had practiced as an eye, ear, nose and throat specialist in Battle Creek for 57 years. A graduate of the Wayne State University Medical School in 1906, he had been head of the eye, ear, nose and throat department of the Battle Creek Sanitarium for 15 years.

Doctor Haughey had received many awards. News of his last honor reached him before he entered the hospital. The award from The MSMS Council as "Editor Emeritus" of the MSMS JOURNAL was accepted by his son Phillip in ceremonies in the hospital lobby. In 1960, he was honored by the American Medical Association for having attended every annual AMA meeting in 50 years. In 1960, he was cited for special recognition by a national organization of Editors of State Medical Society Journals. The MSMS JOURNAL long has been recognized as one of the "superior" medical journals in the nation.

In 1949, at the Annual Session, Doctor Haughey served as "President for a Day" of the State Medical Society. He also was a past president of the Michigan Medical Service and as the MSMS JOURNAL editor, he attended every Blue Shield board meeting for many years.

Wayne State University cited him in 1954 for his outstanding contributions to medicine.

Funeral services were held at St. Anne's Catholic Church at Gull Lake, a community west of Battle Creek, where he had lived his entire life.

* * *

An appropriate tribute to Doctor Haughey will appear in the September issue of THE JOURNAL MSMS *with a complete biography.*

FRANK A. BOET, M.D., 82, Grand Rapids general practitioner, died June 13, 1963.

A lifelong resident of Grand Rapids, Doctor Boet was a 1907 graduate of the Detroit College of Medicine (now Wayne State University College of Medicine). He practiced medicine in Grand Rapids from 1909 until his retirement in 1959.

He was a Life Member of the Michigan State Medical Society and a member of Nu Sigma Nu medical fraternity.

WILLIAM A. GRANT, M.D., 83, of Milford, died June 11, 1963.

A graduate of Saginaw Medical College, Doctor Grant

(Continued on page 836)



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WILLIAM A. GRANT, M.D.

(Continued from page 834)

began practice in Lyons in 1902, and practiced there until World War I when he served in the army medical corps. Following military service he practiced in Detroit for a time before moving to Milford.

He was a Life Member of the Michigan State Medical Society.

MILLARD W. SHELLMAN, M.D., 56, Grand Rapids industrial surgeon, died June 23, 1963.

A lifelong resident of Grand Rapids, Doctor Shellman was a graduate of the University of Michigan Medical School. He was a Fellow of the American College of Surgeons, past president of the Michigan Industrial Physicians and Surgeons Society and was on the consulting staffs of Blodgett and St. Mary's Hospitals.

HERBERT C. WALLACE, M.D., 59, retired Saginaw physician and former U. S. Army colonel, died June 17, 1963.

A graduate of the University of Michigan Medical School, Doctor Wallace interned at St. Mary's Hospital in Saginaw and practiced medicine in Saginaw until 1940 when he served as a captain in the Army medical corps. In 1945, he returned to practice in Saginaw until 1950 when he returned to military service in Korea. From 1953 to 1955 he served with the American Military Mission in Iran, then returned to the U. S. until his active duty separation in 1958.

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Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review as expedient.

CIBA FOUNDATION SYMPOSIUM ON RENAL BIOPSY. Clinical and Pathological Significance. Editors for the Ciba Foundation G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Margaret P. Cameron, M.A. With 134 illustrations. Boston: Little, Brown and Company, 1962. Price, $10.50.

This is a symposium based on experiences with renal biopsies, but actually serves as an up-to-date source book on renal disease. The Chairman is Dr. Rich of Johns Hopkins and the bulk of the text is in conversational form with the various participants mentioned by name.

It is well illustrated although some of the electron microscopic photographs probably will not contribute as much as they might to the casual reader; they did not prove to be particularly informative to the reviewer.

The risk of hemorrhage following biopsy is limited to two pages but the statistics are explicit and, while an occasional nephrectomy has been required, the hazard apparently is small.

It is pointed out that the procedure of renal biopsy is actually the only exact method for the diagnosis of amyloidosis. The index is somewhat inadequate but the book is recommended.

A.A.H.

THE SURGEON. By W. C. Heinz. Garden City, New York: Doubleday and Company, Inc., 1963. Price, $3.95.

Within the current atmosphere of emphasis on medical dramas Heinz's novel adds little that is new either of a literary or informative nature. The book, which is based on a day in the life of an eminent thoracic surgeon, faces the problems and decisions concerned with the life and death of patients. It reveals the doctor's feelings as he makes his decisions and calls upon his past as a background for his knowledge.

AN INTRODUCTION TO THE STUDY OF DISEASE. By William Boyd, M.D., Dipl. Psychiat., M.R.C.P. (Edin.), Hon. F.R.C.P. (Edin.), F.R.C.P. (Lond.), F.R.C.S. (Can.), F.R.S. (Can.) (Sask.), (Queen's), D.Sc. (Man.), M.D. (Hon.) Oslo. Fifth edition, thoroughly revised. 174 illustrations and 4 colored plates. Philadelphia: Lea & Febiger, 1962. Price, $7.50.

As stated in the Preface, this book is intended for two groups; First, those who are in the paramedical field such as nurses, laboratory technologists, x-ray technicians, medical secretaries, record librarians, medical photographers, et cetera. It is pointed out that every physician can practice better medicine if these individuals are familiar with basic pathology.

The second group who would be interested in this text is the college student who may be toying with the idea of entering medicine and also the premedical student.

It is felt that this book probably would make an excellent gift to individuals in these two broad groups. The author is noted for his clarity and also for his humorous and philosophic observations in his other writings. An example of the compact and readily understandable nature of the text is the half page article devoted to polycythemia.

A.A.H.

BOOKS RECEIVED

THE EXOCRINE PANCREAS. Normal and Abnormal Functions. Ciba Foundation Symposium. Editors for the Ciba Foundation: A. V. S. de Reuck, M.SC., D.I.C., A.R.C.S., and Margaret P. Cameron, M.A. 91 illustrations. Boston: Little, Brown and Company, 1962. Price, $11.50.

STRABISMUS. Symposium of the New Orleans Academy of Ophthalmology. By Raynold N. Berke, M.D. Harold Whaley Brown, M.D. David G. Cogan, M.D. John Woodworth Henderson, M.D., Ph.D. Arthur Jampolsky, M.D. Marshall M. Parks, M.D. Edited by George M. Haik, M.D. Illustrated. St. Louis: C. V. Mosby Company, 1962. Price, $18.00.

CANCER, Diagnosis, Treatment and Prognosis. By Lauren V. Ackerman, M.D., Professor of Surgical Pathology and Pathology, Washington University School of Medicine, St. Louis, Mo.; Surgical Pathologist, Barnes Hospital and Affiliated Hospitals, St. Louis, Mo.; Consultant to the Ellis Fischel State Cancer Hospital, Columbia, Mo.; Consultant to the Armed Forces Institute of Pathology; Member, Subcommittee on Oncology, National Academy of Sciences—National Research Council. Juan A. del Regate, M.D., Director, Penrose Cancer Hospital, Colorado Springs, Colorado; Associate Professor of Radiology, University of Colorado Medical School, Denver, Colorado; Member, Clinical Studies Panel, National Cancer Chemotherapeutic Center; Member, Advisory Commission on Biology and Medicine, University of Puerto Rico Nuclear Center; Consultant, Lackland Air Force Base Medical Center; Consultant, Veterans Administration Hospitals. With 799 text illustrations and 4 color reproductions. Third edition. Saint Louis: C. V. Mosby Company, 1962. Price, $29.50.

NEW AND NONOFFICIAL DRUGS. An annual compilation of available information on drugs, including their therapeutic, prophylactic and diagnostic status, as evaluated by the Council on Drugs of the American Medical Association. 1963. J. B. Lippincott Company. Philadelphia and Montreal. (No price given.)

PEDIATRICS. Thirteenth Edition. By L. Emmett Holt, Jr., Professor of Pediatrics, New York University School of Medicine; Consultant in Pediatrics, Bellevue Hospital, New York. Rustin McIntosh Carpentier, Professor Emeritus of Pediatrics, Columbia University; Consultant in Pediatrics, Presbyterian Hospital; Former Director of Pediatric Service, Babies Hospital, New York. Henry L. Barnett, Professor and Chairman, Department of Pediatrics, Albert Einstein College of Medicine, Yeshiva University; Director of Pediatric Service, Bronx Municipal Hospital Center, New York. New York: Appleton-Century-Crofts, Inc. (no price given)

CLINICAL OBSTETRICS AND GYNECOLOGY. (Volume 5, Number 1, March, 1962). The Newborn, Edited by Michael Newton, M.D.; Office Gynecology, Edited by Roger B. Scott, M.D. New York: Hoeber Medical Division, Harper and Brothers. Published Quarterly; sold by subscription only, $18.00 a year.

Classified Advertising

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PLAN FOR PSYCHIATRIC RESIDENCY for July, 1964? NIMH General Practitioner Program: $12,000 yearly, partially tax free. Michigan vacationland. Three-year approved. Balanced didactic and clinical training. Dr. Curtis W. Page, Training Director, Traverse City State Hospital, Traverse City, Michigan.

WANTED: General Practitioner to take over practice of a retiring physician in a city of 25,000 with a new 150-bed hospital. Only expense would be office rental. If interested, contact J. D. Rogers, M.D., 146 Toledo Street, Adrian, Michigan.

PHYSICIANS WANTED: Locum Tenens, August 5-18 and August 26-September 7. Diagnostic Radiology—Two small hospitals in Detroit. Will accept residents who have completed two years of Diagnostic Radiology. Michigan license required. Reply: Box 16, 120 West Saginaw Street, East Lansing, Michigan.

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FOR SALE: Detroit. Golden opportunity for young physician to buy long-established general practice with completely furnished office. Easy terms, will introduce and assist in every way possible. Contact: C. M. Clark, M.D., 2605 Holbrook Ave., Detroit 12, Michigan.

STAFF PHYSICIAN: Immediate vacancies for Staff Physicians to be found at Southwestern Michigan Tuberculosis Sanatorium, Kalamazoo, Michigan; Copper Country Tuberculosis Sanatorium, Hancock, Michigan; and Veterans' Facility, Grand Rapids, Michigan. Salary range $10,356 to $15,347 annually, depending on qualifications. Effective July 14, 1963. All Michigan civil service benefits, including position security, an excellent state contributory insurance program, and an outstanding retirement plan. For additional information, contact Mr. Richard D. Crable, Michigan Civil Service Commission, 320 South Walnut Street, Lansing 13, Michigan. An equal opportunity employer.

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References: 1. A.M.A. Council on Drugs: J.A.M.A. 183:469 (Feb. 9) 1963. 2. Gruenberg, F.: Curr. Ther. Res. 2:1 (Jan.) 1960.

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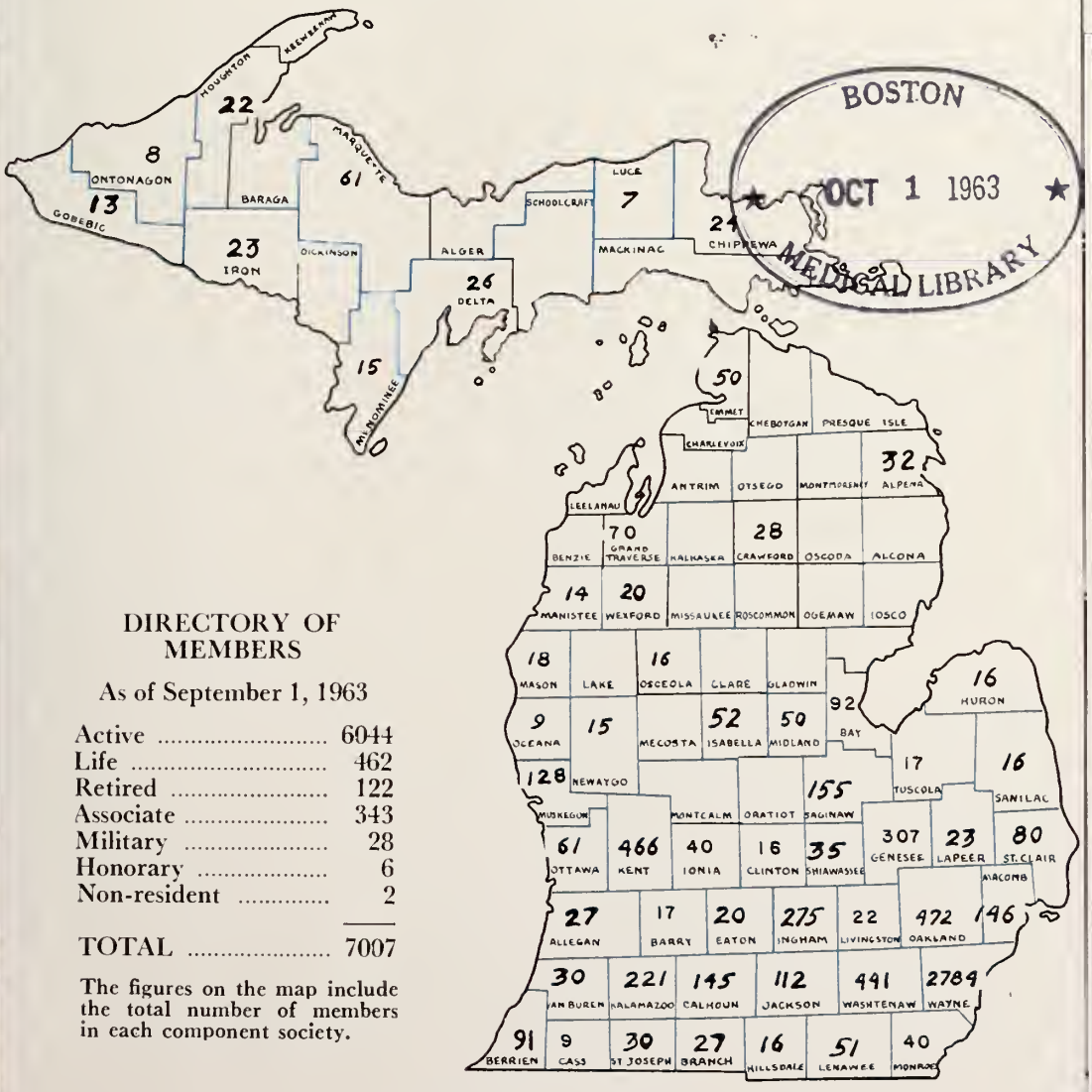
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STATE MEDICAL SOCIETY
SEPTEMBER 1963 • VOLUME 62 • NUMBER 9

(This number is composed of two sections, of which this is Section 2)

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Directory of Members—1963

The colored lines on the map indicate the boundaries for the component medical societies.



DIRECTORY OF MEMBERS

As of September 1, 1963

Active	6044
Life	462
Retired	122
Associate	343
Military	28
Honorary	6
Non-resident	2
TOTAL	7007

The figures on the map include the total number of members in each component society.

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This MSMS Directory reports the membership of each component medical society. However, all the counties are listed below in an effort to make the Index serve more effectively as a ready reference.

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Guide to Help Locate Cities within the Counties

This guide matches up the counties for all Michigan communities of 1,000 population or more.*

CITY and COUNTY

Adrian (Lenawee)
Albion (Calhoun)
Algonac (St. Clair)
Allegan (Allegan)
Alma (Gratiot)
Almont (Lapeer)
Alpena (Alpena)
Ann Arbor (Washtenaw)

Bad Axe (Huron)
Bangor ((Van Buren)
Battle Creek (Calhoun)
Bay City (Bay)
Belding (Ionia)
Belleville (Wayne)
Bellevue (Eaton)
Benton Harbor (Berrien)
Berkley (Oakland)
Berrien Springs (Berrien)
Bessemer (Gogebic)
Big Rapids (Mecosta)
Birmingham (Oakland)
Blissfield (Lenawee)
Bloomfield Hills (Oakland)
Boyne City (Charlevoix)
Brighton (Livingston)
Bronson (Branch)
Brookline (Jackson)
Buchanan (Berrien)

Cadillac (Wexford)
Calumet (Houghton)
Capac (St. Clair)
Carleton (Monroe)
Caro (Tuscola)
Carson City (Montcalm)
Cass City (Tuscola)
Cassopolis (Cass)
Cedar Springs (Kent)
Center Line (Macomb)
Charlevoix (Charlevoix)
Charlotte (Eaton)
Cheboygan (Cheboygan)
Chelsea (Washtenaw)
Chesaning (Saginaw)
Clare (Clare)
Clawson (Oakland)

CITY and COUNTY

Clinton (Lenawee)
Clio (Genesee)
Coldwater (Branch)
Coloma (Berrien)
Colon (St. Joseph)
Constantine (St. Joseph)
Coopersville (Kent)
Corunna (Shiawassee)
Croswell (Sanilac)

Davison (Genesee)
Dearborn (Wayne)
Decatur (Van Buren)
Detroit (Wayne)
Dexter (Washtenaw)
Dowagiac (Cass)
Dundee (Monroe)
Durand (Shiawassee)

East Ann Arbor (Washtenaw)
East Detroit (Macomb)
East Grand Rapids (Kent)
East Jordan (Charlevoix)
East Lansing (Ingham)
East Tawas (Iosco)
Eaton Rapids (Eaton)
Ecorse (Wayne)
Escanaba (Delta)
Essexville (Bay)
Evart (Osceola)

Farmington (Oakland)
Fenton (Genesee)
Ferndale (Oakland)
Flat Rock (Wayne)
Flint (Genesee)
Flushing (Genesee)
Fowlerville (Livingston)
Frankenmuth (Saginaw)
Frankfort (Benzie)
Fraser (Macomb)
Fremont (Newaygo)

Galesburg (Kalamazoo)
Garden City (Wayne)
Gaylord (Otsego)
Gladstone (Delta)

CITY and COUNTY

Gladwin (Gladwin)
Grand Haven (Ottawa)
Grand Ledge (Eaton)
Grand Rapids (Kent)
Grandville (Kent)
Grayling (Crawford)
Greenville (Montcalm)
Grosse Pointe (Wayne)
Grosse Pointe Farms (Wayne)
Grosse Pointe Park (Wayne)
Grosse Pointe Shores (Wayne & Macomb)
Grosse Pointe Woods (Wayne & Macomb)

Hamtramck (Wayne)
Hancock (Houghton)
Harbor Beach (Huron)
Harbor Springs (Emmet)
Hart (Oceana)
Hartford (Van Buren)
Hastings (Barry)
Hazel Park (Oakland)
Highland Park (Wayne)
Hillsdale (Hillsdale)
Holland (Ottawa)
Holly (Oakland)
Homer (Calhoun)
Houghton (Houghton)
Howell (Livingston)
Hubbell (Houghton)
Hudson (Lenawee)
Hudsonville (Ottawa)
Huntington Woods (Oakland)

Imlay City (Lapeer)
Inkster (Wayne)
Ionia (Ionia)
Iron Mountain (Dickinson)
Iron River (Iron)
Ironwood (Gogebic)
Ishpeming (Marquette)
Ithaca (Gratiot)

Jackson (Jackson)
Jonesville (Hillsdale)

*See page 1 for Index by counties.

CITY and COUNTY

Kalamazoo (Kalamazoo)
Kalkaska (Kalkaska)
Kingsford (Dickinson)

Lake Linden (Houghton)
Lake Odessa (Ionia)
Lake Orion (Oakland)
Lakeview (Calhoun)
L'Anse (Baraga)
Lansing (Ingham)
Lapeer (Lapeer)
Laurium (Houghton)
Lawton (Van Buren)
Leslie (Ingham)
Lincoln Park (Wayne)
Livonia (Wayne)
Ludington (Mason)

Mancelona (Antrim)
Manchester (Washtenaw)
Manistee (Manistee)
Manistique (Schoolcraft)
Manton (Wexford)
Marcellus (Cass)
Marine City (St. Clair)
Marlette (Sanilac)
Marquette (Marquette)
Marshall (Calhoun)
Marysville (St. Clair)
Mason (Ingham)
Melvindale (Wayne)
Menominee (Menominee)
Michigan Center (Jackson)
Middleville (Barry)
Midland (Midland)
Milan (Monroe & Washtenaw)
Milford (Oakland)
Millington (Tuscola)
Monroe (Monroe)
Montague (Muskegon)
Morenci (Lenawee)
Mount Clemens (Macomb)
Mount Morris (Genesee)
Mount Pleasant (Isabella)
Munising (Alger)
Muskegon (Muskegon)
Muskegon Heights (Muskegon)

Nashville (Barry)
Negaunee (Marquette)
Newaygo (Newaygo)
New Baltimore (Macomb & St. Clair)
Newberry (Luce)
New Buffalo (Berrien)

CITY and COUNTY

Niles (Berrien)
North Muskegon (Muskegon)
Northville (Wayne & Oakland)
Norway (Dickinson)

Oak Park (Oakland)
Onaway (Presque Isle)
Ontonagon (Ontonagon)
Otsego (Allegan)
Ovid (Clinton)
Owosso (Shiawassee)
Oxford (Oakland)

Painesdale (Houghton)
Parchment (Kalamazoo)
Paw Paw (Van Buren)
Pentwater (Oceana)
Perry (Shiawassee)
Petersburg (Monroe)
Petoskey (Emmett)
Pigeon (Huron)
Pinconning (Bay)
Plainwell (Allegan)
Pleasant Ridge (Oakland)
Plymouth (Wayne)
Pontiac (Oakland)
Port Huron (St. Clair)
Portland (Ionia)

Quincy (Branch)

Reading (Hillsdale)
Reed City (Osceola)
Richmond (Macomb)
River Rouge (Wayne)
Riverview (Wayne)
Rochester (Oakland)
Rockford (Kent)
Rockwood (Wayne)
Rogers City (Presque Isle)
Romeo (Macomb)
Roseville (Macomb)
Royal Oak (Oakland)

Saginaw (Saginaw)
Saint Clair (St. Clair)
Saint Clair Shores (Macomb)
Saint Ignace (Mackinac)
Saint Johns (Clinton)
Saint Joseph (Berrien)
Saint Louis (Gratiot)
Saline (Washtenaw)
Sandusky (Sanilac)
Saugatuck (Allegan)

CITY and COUNTY

Sault Sainte Marie (Chippewa)
Schoolcraft (Kalamazoo)
Scottville (Mason)
Sebewaing (Huron)
Shelby (Oceana)
Southfield (Wayne)
South Haven (Van Buren)
South Lyon (Oakland)
Sparta (Kent)
Spring Lake (Ottawa)
Stambaugh (Iron)
Standish (Arenac)
Stanton (Montcalm)
Stockbridge (Ingham)
Sturgis (St. Joseph)
Sylvan Lake (Oakland)

Tawas City (Iosco)
Tecumseh (Lenawee)
Three Rivers (St. Joseph)
Traverse City (Grand Traverse)
Trenton (Wayne)

Union City (Branch & Calhoun)
Utica (Macomb)

Vandercook Lake (Jackson)
Van Dyke (Macomb)
Vassar (Tuscola)
Vicksburg (Kalamazoo)

Wakefield (Gogebic)
Walled Lake (Oakland)
Warren (Macomb)
Watervliet (Berrien)
Wayland (Allegan)
Wayne (Wayne)
West Branch (Ogenaw)
Whitehall (Muskegon)
White Pigeon (St. Joseph)
Wyandotte (Wayne)
Wyoming (Kent)

Yale (St. Clair)
Ypsilanti (Washtenaw)

Zeeland (Ottawa)

Michigan State Medical Society

Directory of Members, 1963

Listed by Component Medical Societies

(Special Memberships are indicated as follows: "L" for Life Members; "M" for Military Members; "R" for Retired Members; "A" for Associate Members; all others are Active Members)

Numbers in parentheses indicate County Society Code Numbers used in Alphabetical Roster

ALLEGAN COUNTY MEDICAL SOCIETY (10)

Brachman, A. Peter, Jr.....222 Trowbridge St., Allegan
Brown, Lewis F.....133 E. Allegan St., Otsego
Chase, Walter E.....137½ N. Main St., Plainwell
Clark, James I. (A).....Box B, Fennville
Dickinson, Clyde A. Wayland
Doorn, Henry A...3032 Burlingame Ave., Wyoming City
Everett, D. W.....Plainwell Sanitarium, Plainwell
Goddard, G. B.....218 E. Orleans, Otsego
Goude, Albert G. (A)
Hays, James D.....Douglas
Johnson, Elwin B.....144 Brady St., Allegan
Johnson, Harrison H. (L).....Wayland
Keller, Van O.....Otsego
Mahan, James E.....402 Trowbridge St., Allegan
Medill, Wilbur C.....139 N. Main St., Plainwell
Miller, Kenneth C.....Saugatuck
Mitchell, Abbott B.....County Health Dept., Allegan
Pone, Janis Martin
Proos, Richard A.....304 Dix St.,Otsego
Ramseyer, Gladwin E.....125 E. Bridge, Plainwell
Schneiter, Harry E.....425 Cutler St., Allegan
Schock, William H.....315 Maple St., Saugatuck
Topp, Elwin W.....502 N. Main St., Plainwell
Van Der Kolk, Bert.....Hopkins
Vander Voord, Gerald.....312 E. Plum St., Wayland
Vaughan, Willard R. (L).....Plainwell
Wiseman, Bertha A.....Box 177, Allegan

ALPENA-ALCONA-PRESQUE ISLE COUNTY MEDICAL SOCIETY (14)

Arscott, Edward F.....Rogers City
Brown, Donald C.....312 E. Chisholm St., Alpena
Bunting, John W.....110 N. 1st Ave., Alpena
Burkholder, H. J. (L).....122 N. Second Ave., Alpena
Cohn, Stuart L.....1253 W. Washington, Alpena
Constantine, Aeneas Harrisville
Finch, Donald E.....Onaway
Foley, Arthur L.....2001 Brampton Court, Ann Arbor
Foley, Richard Rogers City
Fox, William L.....601 W. Chisholm St., Alpena
Grause, Thomas J.....312 E. Chisholm St., Alpena
Henderson, D. G.....Alpena General Hosp., Alpena
Hier, Edward A.....125 N. Second Ave., Alpena
Jackson, Wm. F.....Rogers City
Kessler, Harold.....312 E. Chisholm St., Alpena
Kutsche, W. F.....208 Lake St., Oscoda
Leopard, J. M.....312 E. Chisholm, Alpena
Lipski, John G. (A).....State Hospital, Traverse City
Nesbitt, Wm. E.....123 N. 2nd Ave., Alpena
Newman, Roy E.....Alpena General Hosp., Alpena
O'Dell, F. C., Jr.....110 W. Chisholm St., Alpena
Parmenter, Elbert S.....Box 192, Alpena
Ramsey, J. Allen.....312 E. Chisholm, Alpena
Ries, Robt. C.....Rogers City
Riker, John L.....303 N. Second Ave., Alpena
Rowell, Wilfred J.....Alpena Gen. Hosp., Alpena
Spens, James E.....123 N. Second Ave., Alpena
Stump, G. D.....123 N. Second Ave., Alpena
Wagoner, Darwin E.....5007 N. Cedar Lake Rd., Oscoda
Watkins, T. M.....312 E. Chisholm St., Alpena
Wienczewski, T. W.....811 Chisholm St., Alpena
Wilson, Chas. S. (L).....730 State Ave., Alpena

BARRY COUNTY MEDICAL SOCIETY (18)

Birk, Wilbur R.....110 W. Center, Hastings
Brown, Jack A.....303 Broadway, Middleville
Castleman, Douglas H.....110 W. Center, Hastings
Finnie, Raymond G.....118 E. Walnut St., Hastings
Gwinn, Alexander B.....102 E. State St., Hastings
Heaslip, Jos. D. (R).....627 W. Madison St., Hastings
Huebner, R. J.....110 W. Center, Hastings
Lofdahl, Stewart (R).....Rt. 1, Box 172, St. Charles, Ill.
Logan, Wesley G.....City Bank Bldg., Hastings
Lundeen, John G.....595 Jordan Lake, Lake Odessa
Morrill, Charles E.....400 W. State St., Hastings
Myers, Thos. W.....307 N. Main St., Nashville
Noah, Melvin L. (A)..St. Marys Hospital, Grand Rapids
Phelps, Everett L.....118 E. Walnut St., Hastings
Pryor, Robt. B.....400 W. State St., Hastings
Tromp, Jack L.....R.D. 3, Lake Odessa
Wedel, Herbert S.....110 W. Center, Hastings

BAY-ARENAC-IOSCO COUNTY MEDICAL SOCIETY (22)

Alcorn, Kent A. 1420 Center Ave., Bay City
Alcorn, Marshall W. 1420 Center Ave., Bay City
Allen, Arthur D. 101 W. John St., Bay City
Antle, Robert C. 101 W. John St., Bay City
Asbury, Richard B. 2110 16th St., Bay City
Asline, John N. 207 N. Walnut St., Bay City
Austin, Justus J. Tawas City
Bowman, David A. V.A. Hospital, Topeka, Kansas
Bozdech, Jiri Josef 900 N. Jackson, Bay City
Brenner, Frederick 900 N. Jackson, Bay City
Brinkman, Harvey H. 116 W. State St., East Tawas
Brown, Geo. M. 207 N. Walnut St., Bay City
Campbell, Donald A. 700 Borton, Essexville
Campbell, John S. 1838 McKinley Ave., Bay City
Chapin, Fredk. J. 2121 Center Ave., Bay City
Connelly, C. J. 1104 S. Madison Ave., Bay City
Cook, Hugh K. 101 W. John St., Bay City
Cook, Raymond R. 1115 Fifth Street, Bay City
Cooper, James C. 705 Oak St., Essexville
Cosens, Stanley A. 101 W. John St., Bay City
Crissey, Robt. R. 101 W. John St., Bay City
Criswell, Robt. H. 721 Washington Ave., Bay City
Csonka, Nicholas 1308 Columbus Ave., Bay City
Dardas, Michael J. 1413 Center Ave., Bay City
Dolbee, Malcolm K. Box 518, Standish
Ellison, Alfred Jr. 101 John St., Bay City
Follis, Wm. M. 101 W. John, Bay City
Gamble, Wm. G., Jr. 2010 5th Ave., Bay City
Gehman, J. R. Standish
Geneczko, John T. 1102 Columbus Ave., Bay City
Grigg, John W. 2110 Sixteenth St., Bay City
Hafford, Robert C. 101 W. John St., Bay City
Hagelshaw, Gayland L. 101 W. John St., Bay City
Hess, Chas. L. (R) 110 E. Coronado Rd., Phoenix 4, Ariz.
Heuser, Harold H. 916 Washington Ave., Bay City
Hickner, Lawrence P. 101 W. John St., Bay City
Horowitz, Saml. F. 1415 Center Ave., Bay City
Howland, Walter L. P.O. Box 633, Pinconning
Huckins, Rodger S. 1802 Broadway, Bay City
Jacoby, Abraham H. 2202 Ninth St., Bay City
Jacques, J. E. Tawas City
Jaffe, Martin D. 2110 16th Street, Bay City
Jens, Otto F. 1506 Prairie St., Essexville
Johnson, Orlen J. 207 N. Walnut St., Bay City
Jones, M. Culver 900 N. Jackson, Bay City
Kelly, Larry Stanley Tawas City
Kessler, Mana 311 Center Ave., Bay City
Kessler, Sabina 311 Center Ave., Bay City
Knobloch, Howard T. 1102 Columbus, Bay City
Kruger, Harold F. 300 N. Henry, Bay City
Kulinski, Eugene J. 601 Ames Ct., Bay City
Langin, John L. 100 15th St., Bay City
MacRae, Leonard D. 813 Sherman St., Bay City
Mayne, John C. 101 W. John St., Bay City
McGee, Harry B. 2110 16th St., Bay City
McGee, Peter L. 2110 16th St., Bay City
McSherry, Leo B., Jr. 1102 Columbus Ave., Bay City
Medvezky, Michael J. 1106 S. Madison Ave., Bay City
Miller, Edwin C. 101 W. John St., Bay City
Moeller, Arlyn 700 Borton Ave., Essexville
Moore, Allen B. 700 Borton Ave., Essexville
Moore, Neal R. 704 N. Jackson, Bay City
Mosier, Dwight J. 101 W. John St., Bay City
Nixon, Robert S. 101 W. John St., Bay City
Payea, Norman P. 217 Newman St., East Tawas
Pearson, Stanley M. 101 W. John St., Bay City
Pelczar, Walter E. 321 N. Johnson St., Bay City
Prophater, Robt. C. 202 Boehringer Ct., Bay City
Reddick, C. E. Court House, Bay City
Roberge, Jerome T. 695 Alpine Beach, Bay City
Rodda, E. H. 101 W. John St., Bay City
Rogers, Charles S. 101 W. John St., Bay City
Rowe, Paul W. Mercy Hospital, Bay City
Schmelzer, Wm. J. 602 Mercer St., P.O. 746, Pinconning
Shafer, Harold C. 101 W. John St., Bay City
Shields, Hubert L. 101 W. John St., Bay City
Staley, Hugh O. Omer
Standiford, David 2110 16th St., Bay City
Stankey, Robt. M. 310 Pine St., Essexville
Stroia, Livius N. 101 W. John St., Bay City
Sutton, R. L., Jr. 116 W. State St., East Tawas
Sweet, Irwin Gladwin
Taheri, Zia E. 1411 Center Avenue, Bay City
Tarter, Clyde S. 1712 Center Ave., Bay City
Tompkins, Dana A. Pinconning, Mich.
Treadway, Gaylord 900 N. Jackson, Bay City
Vail, Harry F.
Wilson, Thos. G. (R) Venice, Fla.
Woodburne, Harris L. 1420 Center St., Bay City
Wright, Thomas B. 101 W. John St., Bay City
Zaremba, Aloysius J. (L) 108 S. Madison Ave., Bay City
Ziliak, Alois L., Jr. 3393 Kiesel Rd., Bay City

BERRIEN COUNTY MEDICAL SOCIETY (26)

Asselin, Dean R. 2817 S. State St., St. Joseph
Atkinson, Robert L. 1626 Langley Ave., St. Joseph
Bailey, John H. 2150 Samuel Ave., Benton Harbor
Beal, Gerald N. Sheperd Benning Bldg., St. Joseph
Benner, Wm. H. 700 Empire Rd., Benton Harbor
Bieri, Dixon L. 208 Brown School Rd., St. Joseph
Bliesmer, August F. 505 Pleasant St., St. Joseph
Brink, John W. 811 Myrtle St., St. Joseph
Bronfenbrenner, Jack 687 E. Empire Ave., Benton Harbor
Bruni, John R. 1 South Fifth St., Niles
Camp, Donald C. 8 N. St. Joseph Ave., Niles
Cawthorne, Harold J. (R) Rt. 4, Box 201, Coloma
Chickering, Wm. A. 205 E. Delaware St., Benton Harbor
Cilella, S. G. Pawating Hospital, Niles
Colligan, Joseph North Portage St., Buchanan
Conway, Jos. Watervliet
Conybeare, Robt C. 756 Pipestone, Benton Harbor
Cooper, Wm. L. Rt. 1 Paw Paw Island, Coloma
Crowell, Richard C. 519 Ship St., St. Joseph
Dailey, Walter S. 122 Grant St., Niles
Dalgleish, Archie J. 460 N. Main St., Watervliet
Elghammer, Richard M. 1106 Highland Ave., St. Joseph
Elliott, J. Colin 802 E. Front St., Buchanan
Emery, Clayton S. 1020 Niles Ave., St. Joseph
Emery, Wm. K. 1020 Niles Ave., St. Joseph
Faber, Michael 756 Pipestone St., Benton Harbor
Fattic, Grover R., Jr. Box 427, Niles
Feeley, Marshall J. 2516 Niles Ave., St. Joseph
Friedman, Morris E. Barton St., New Buffalo
Galles, James O. 275 Paw Paw Ave., Coloma
Garrett, Evan L. P.O. Box 427, Niles
Gillette, Clarence (L) R.F.D. 4 M., 60 W., Niles
Gould, Samuel H. 127 Napier Ave., Benton Harbor
Grayson, Chas. J. 4 Maple St., Three Oaks
Green, Barbara G. 2600 Morton St., St. Joseph
Green, Robt. L. 2600 Morton St., St. Joseph
Grundset, Harold M. 530 Christiana Dr., Niles
Hassan, D. Kent 802 E. Front St., Buchanan
Haupt, Edward C. 687 E. Empire, Benton Harbor
Hayes, Thos. P. 2821 State St., St. Joseph
Hershey, Noel J. P.O. Box 222, Niles

Hills, David W.....2821 State St., St. Joseph
Holt, Robt. E.....9 S. St. Joseph Ave., Niles
Howard, Frank W.....756 Pipestone, Benton Harbor
Hudnutt, Dean.....811 Myrtle St., St. Joseph
Huff, Harold D.....126 Main St., Niles
Irgens, Edwin R.....11 Peoples St. Bk. Bldg., St. Joseph
Johnston. Wm. H.....2522 Niles Ave., St. Joseph
Kelsall, Harvey I.....1600 Niles Ave., St. Joseph
Kenfield, W. J.....505 Pleasant St., St. Joseph
Kennedy, F. Alan.....315 Fidelity Bldg., Benton Harbor
King, Frank A., Jr.....169 Michigan St., Benton Harbor
Klos, Henry J.....2700 Highland Ct., St. Joseph
Landgraf, Robt. L.....P.O. Box 222, Niles
Leva, John B.....1122 Salem Ave., Benton Harbor
Lindenfeld, Fredk. H.....8 N. St. Joseph Ave., Niles
Lininger, Richard E.....2712 Highland Ct., St. Joseph
Manning, John T.....1150 Miami Rd., Benton Harbor
May, A. J.....2821 State St., St. Joseph
McLelland, J. T.....Mercy Hosp. X Ray Dept., Benton Harbor
McNabb, Arthur A.....469 Main St., Watervliet
Mesirow, Stanley M.....687 E. Empire Ave., Benton Harbor
Miller, Edward A. (R)..420 Kimmel St., Berrien Springs
Moore, T. Scott.....P.O. Box 416, Niles
O'Toole, John.....133 E. Napier, Benton Harbor
Ozeran, Chas. J.....127 E. Napier, Benton Harbor
Padelford, Wm. J.....South Lyon
Payne, Charles E.....925 Pipestone St., Benton Harbor
Peshka, David K.....P.O. Box 427, Niles
Polansky, Sanford.....84 W. Main St., Benton Harbor
Porter, Chas. B.....1589 Colfax Ave., Benton Harbor
Pritchard, Harold M.....502 Broadway, Niles
Rague, Paul O.....960 Agard, Benton Harbor
Rambo, Joseph J.....505 Lake St., Bridgman
Ray, Dean K.....2522 Niles, St. Joseph
Reagan, Robt. E.....232 Windsor, Benton Harbor
Richmond, Dean M.....314 State St., St. Joseph
Ruth, J. Griswold.....507 Britain Ave., Benton Harbor
Skinner, James W.....460 Ridgeway St., St. Joseph
Smith, W. B.....133 E. Napier, Benton Harbor
Sowers, Bouton F.....756 Pipestone St., Benton Harbor
Strayer, John W.....P.O. Box 222, Niles
Stulik, Chas. K.....Town Line Rd., P.O. Box 98, Union Pier
Turner, John J.....2817 S. State St., St. Joseph
Urist, Maurice D.....454 Pipestone St., Benton Harbor
Valantiejus, John A.....Rt. 2, Cedar Lane Farm, New Buffalo
Vastine, Russell J., Jr.....430 W. Chicago, Buchanan
Watkins, Richard W.....131 E. Napier, Benton Harbor
Westervelt, H. O.....539 Pearl St., Benton Harbor
Woodford, Hackley E...191 Michigan St., Benton Harbor
Zick, Luther H.....2522 Niles Ave., St. Joseph

BRANCH COUNTY MEDICAL SOCIETY (30)

Aldrich, Napier S.....162 Marshall St., Coldwater
Bacon, Charles R.....300 E. Chicago St., Coldwater
Bailey, James E., Jr.....300 E. Chicago St., Coldwater
Beck, Perry C. (L).....Box 25, Bronson
Bien, Walter W. J. (L).....65 N. Monroe St., Coldwater
Burke, James M.....40 Balfour Dr., Coldwater
Coates, Carl A.....135 Stringtown R.F.D. 1, Quincy
Culver, Bert W. (L).....72 Division St., Coldwater
Culver, Dean T.....173 E. Chicago St., Coldwater
Fraser, Robt. J.....22 W. Pearl St., Coldwater
Geib, Ormond D.....State Home Trng. Sch., Coldwater
Gomley, Henry C.....108 E. Chicago St., Bronson
Harris, Donald M.....35 S. Sprague St., Coldwater
Heffelfinger, John C.....292 E. Chicago Ave., Coldwater
Hoeksema, Ronald H.....292 E. Chicago St., Coldwater
Leitch, Robt. M.....401 Ann St., Union City
Meier, Harold J.....87 W. Pearl St., Coldwater
Mooi, Henry R.....292 E. Chicago St., Coldwater
Moss, Harvey L.....47 Carlyle, Coldwater
Nettleman, Wm. E.....136 E. Pearl St., Coldwater
Olmsted, Kenneth L.....675 Monroe, Coldwater
Rennell, Edwin J.....Coldwater State Home, Coldwater
Rick, John J.....61 E. Chicago St., Coldwater
Thomas, James A.....390 E. Chicago St., Coldwater
Walton, Nathaniel J.....Box 148, Coldwater
Weidner, Harold R.....50 Division St., Coldwater
Wise, Robert.....State Hm. & Trng. School, Coldwater

CALHOUN COUNTY MEDICAL SOCIETY (34)

Albright, Arnold A.....401 Security Tower, Battle Creek
Allen, R. H.....191 College, Battle Creek
Amos, Norman H.....1708 Wolverine Tower, Battle Creek
Amos, Norman O.....1708 Wolverine Tower, Battle Creek
Anderson, Harold E...65 W. Michigan Ave., Battle Creek
Arnold, George K. (A).....V.A. Hospital, Ft. Custer
Azuela, Victor.....185 N. Washington, Battle Creek
Bakken, Richard L.....200 College St., Battle Creek
Barden, Stuart P.....Leila Hosp., Battle Creek
Baribeau, Roy H. (L).....65 W. Michigan Ave., Battle Creek
Becker, Harry F. (L).....Box 547, Battle Creek
Berghorst, John (A).....V.A. Hospital, Battle Creek
Bodine, Harold R.....231 North Ave., Battle Creek
Bonifer, Philip P.....231 North Ave., Battle Creek
Boswell, David E.....105 N. Jefferson Ave., Marshall
Brainard, C. W. (L).....148 Wahwah Tay See Way, Battle Creek
Braverman, A. H. (A).....V.A. Hospital, Ft. Custer
Brown, Robt. W.....203 Capital N.E., Battle Creek
Buell, Martin F. (A).....V.A. Hospital, Ft. Custer
Campbell, Alice F.....103 E. Mulberry St., Albion
Campbell, Jack S.....1018 North Ave., Battle Creek
Campbell, Richard J.....140 Capital Ave. N.E., Battle Creek
Capron, M. J., Jr.....806 Security Bk. Bldg., Battle Creek
Caviness, L. Harold.....185 N. Washington, Battle Creek
Chandler, Edward M.....411 Mich. Nat. Bk. Bldg., Battle Creek
Chynoweth, Wm. R. (L)....207 Post Bldg., Battle Creek
Coakes, Jack E.....112 W. Mansion, Marshall
Colquhoun, Graham F.....25 W. Michigan Ave., Battle Creek
Cram, Ralph A.....500 S. Ionia St., Albion
Curry, Robt. K.....Homer
Daly, Harold L., Jr.....500 S. Ionia St., Albion
Daly, Mary.....500 S. Ionia St., Albion
Daly, Miriam I.....500 S. Ionia St., Albion
D'Aversa, Generoso..5535 Columbia Pike, Arlington, Va.
Diamante, Paul J.....70 W. Michigan Ave., Battle Creek
Dickson, Albert R. (L).....250 Champion St., Battle Creek
Dodge, Warren M., Jr.....1207 Wolverine Tower, Battle Creek
Fairbanks, Stephen.....306 S. Superior, Albion
Ferazzi, Patrick S.....1018 North Ave., Battle Creek
Finch, Duward L.....719 Capital Ave. S.W., Battle Creek
Fisher, Robert E.....1501 W. Michigan Ave., Battle Creek
Fraser, Robt. H. (L).....25 W. Michigan Ave., Battle Creek

Funk, L. D.....133 W. Burr Oak, Athens
Gething, Jos. W. (L).....538 W. Michigan Ave., Battle Creek
Giddings, A. M. (L)..103 Dieker Place, St. Mary's, Ohio
Gilfillan, Margery J. (L).....125 56th Ave. S., St. Petersburg, Fla.
Girardot, John G.....25 W. Michigan, Battle Creek
Graubner, Franklin L.....Bogar Theater Bldg., Marshall
Gray, J. Alan.....309 Mich. Natl. Bk. Bldg., Battle Creek
Griffith, Jack C...616 Mich. Nat. Bk. Bldg., Battle Creek
Hamady, Alfred.....1018 North Ave., Battle Creek
Hansen, Edwin L.....216 North Ave., Battle Creek
Hansen, Harvey C.....65 W. Michigan Ave., Battle Creek
Henderson, Philip M.....109 W. Erie, Albion
Henriksen, J. D.....236 Beckwith Dr., Battle Creek
Herman, Louis (A).....V.A. Hospital, Coral Gables, Fla.
Hibbs, Donald K.....117 Sunnyside Dr., Battle Creek
Holtom, Benj. G.....815 Security Tower, Battle Creek
Hubly, James W.....1509 Security Natl. Bk., Battle Creek
Humphrey, Archie E.....864 E. Michigan St., Marshall
Humphrey, Arthur A.....175 College St., Battle Creek
Humphrey, Herbert E.....122 N. Madison St., Marshall
Huntington, John.....710 North Ave., Battle Creek
Jeffrey, James R. (L).....179 N. Washington Ave., Battle Creek
Jones, Aubrey H. (A).....V.A. Hospital, Ft. Custer
Jones, Ernest F. (A)
Jones, Tyre K.....118 W. Green, Marshall
Kavanagh, Thomas W.....710 North Ave., Battle Creek
Keagle, Leland R. (A).....Rt. 1, Box 392, Augusta
Keeler, Kenneth B. (R).....417 Elizabeth St., Albion
Kelleher, Geo. T.....235 North Ave., Battle Creek
Kimball, Arthur S., Jr.....1150 E. Michigan, Battle Creek
Kinde, Matthew R.....250 Champion, Battle Creek
Kingsley, Paul C.....191 College, Battle Creek
Klopp, Edward J.....173 College St., Battle Creek
Knode, Robert Edwin.....407 Mich. Natl. Bk. Bldg., Battle Creek
La France, N. F. (A).....V.A. Hospital, Ft. Custer
Lakke, Gordon W.....163 North Ave., Battle Creek
Lam, Francis L.....408 Capital Ave. S.W., Battle Creek
Lancaster, Vance B.....710 North Ave., Battle Creek
Levine, S. L. (A).....V.A. Hospital, Battle Creek
Levy, Elizabeth H. (A).....145 Fuller Rd., Box 42, Battle Creek
Levy, Jos., Jr.....231 North Ave., Battle Creek
Lewis, Welcome B. (L).....196 Irving Park Dr., Battle Creek
Long, Walter B.....Homer
Lowe, Kenneth H.....231 North Ave., Battle Creek
Lowe, Stanley T.....231 North Ave., Battle Creek
Lund, C. A. E.....96 E. Jackson St., Battle Creek
Marino, Salvator G. (A).....V.A. Hospital, Lebanon, Pa.
McCuaig, Alfred G.....719 Capital St. S.W., Battle Creek
Melges, Fredk. J.....25 W. Michigan Ave., Battle Creek
Mitton, Orland W. (R).....1408 Arizona N.E., Albuquerque, N. Mex.
Morrison, Donald B.....719 Capital S.W., Battle Creek
Mullenmeister, H. F.....275 Capital N.E., Battle Creek
Murillo, Casmir.....235 North Ave., Battle Creek
Mustard, Russell L.....25 W. Michigan Ave., Battle Creek
Norgan, Anne F.....719 Capital Ave. S.W., Battle Creek
Orr, Eli H. (A).....V.A. Hospital, Battle Creek
Parkinson, Chas. E.....Leila Hospital, Battle Creek
Patrick, Gilbert T.....25 W. Michigan Ave., Battle Creek
Pearson, Donald J.....255 North Ave., Battle Creek
Pier, Clarence T. (A).....V.A. Hospital, Battle Creek
Powell, C. E.....632 North Ave, Battle Creek
Powell, Donna (A).....V.A. Hospital, Ft. Custer
Power, John R.....140 Capital Ave. N.E., Battle Creek
Reizner, Bernard Z.....Oaklawn Hospital, Marshall
Richardson, Benson (A).....Dispensary, Ft. Custer
Robbert, John.....191 College, Battle Creek
Rorich, Wilma C. W. (R).....166 N.E. Capital, Battle Creek
Rowan, Russell C.....500 S. Ionia St., Albion
Royer, Clark W.....1331 W. Michigan Ave., Battle Creek
Royer, R. W.....Box 845, San Marcos, Texas
Ryan, Chas. J.....Leila Hosp., Battle Creek
Seifert, Charles (M).....130 Blessing Pl., Austin 4, Texas
Sharp, Ara D. (R).....502 Irwin Ave., Albion
Shellenberger, H. M.....Box 168, Marshall
Shipp, Leland P.....25 W. Michigan Ave., Battle Creek
Sibilsky, A. Clark.....106 Brewer Dr., Battle Creek
Simpson, Robt. S.....700 Capital Ave. S.W., Battle Creek
Slagle, Geo. W.....203 Capital Ave. N.E., Battle Creek
Spencer, Collis M.....308½ S. Superior St., Albion
Stadle, Wendall H. (R).....607 Jennings Landing, Gougac Lake, Battle Creek
Stephenson, C. D.....140 Capital Ave. N.E., Battle Creek
Stiefel, Richard A.....25 W. Michigan Ave., Battle Creek
Strohmenger, Frank J.....500 S. Ionia St., Albion
Taylor, Clifford B.....500 S. Ionia St., Albion
Tazelaar, Myron A.....219 N. Madison St., Marshall
Vander Kamp, Harry (A)....V.A. Hospital, Battle Creek
Vander Voort, Wm. V. (L).....Rt. 4, Hastings
Vaughn, Charles.....175 College, Battle Creek
Verity, Lloyd E.....1002 Security Tower, Battle Creek
Vetne, Gunnar.....725 Capital S.W., Battle Creek
Walker, Chas. S.....709 W. Van Buren St., Battle Creek
Walters, John F.....163 North Ave., Battle Creek
Walters, Wm. D.....175 College St., Battle Creek
Wemmer, Keith S...1472 W. Michigan Ave., Battle Creek
Wencke, Carl G. (L)..1015 Security Tower, Battle Creek
Winslow, Sherwood B.....710 North Ave., Battle Creek
Worgess, Duane R.....799 Capital Ave. N.E., Battle Creek
Yannitelli, S. A.....1331 W. Michigan, Battle Creek
Young, John R.....719 Capital Ave. S.W., Battle Creek
Zaplitny, R. B.....163 North Ave., Battle Creek
Zaplitny, Sophia (A).....34 Ardmoor, Battle Creek
Zheutlin, Bertram.....50 Adams St., Battle Creek
Zindler, Geo. A.....1201 Security Bk. Bldg., Battle Creek

CASS COUNTY MEDICAL SOCIETY (38)

Adams, Uriah M.....Marcellus
Clary, Rudolph I.....216 S. Front St., Dowagiac
Comstock, L. David, Jr.....417 W. High St., Dowagiac
Hickman, John K.....108 W. Division St., Dowagiac
Loupee, Geo. E.....114 West St., Dowagiac
Loupee, Sherman L. (L).....108 Orchard, Dowagiac
Nakas, Osvaldes.....Rt. 1, Cassopolis
Pierce, Frank L. (L).....142 S. Front St., Dowagiac
Pierce, Kenneth C.....417 W. High St., Dowagiac

CHIPPEWA-MACKINAC COUNTY MEDICAL SOCIETY (42)

Allott, Hugh R.....816 Ashmun St., Sault Ste. Marie
Bandy, Festus C. (R)..2431 Hamlin Lane, Sarasota, Fla.
Blair, H. Milton.....300 Court St., Sault Ste. Marie
Cantwell, Earl K.....300-306 Court St., Sault Ste. Marie
Clausen, Claire H.....300 Court St., Sault Ste. Marie
Finlayson, Donald D.....301 E. Spruce St., Sault Ste. Marie
Hagele, Marie A.....126 Park Pl., Sault Ste. Marie
Haines, Ellen R.....Cedar Point, Mackinac Island
Hamel, Herbert E.....St. Ignace

Harrington, Harvey M. (L)....Box 319, Sault Ste. Marie
Howe, Donnell C., Jr.....300 Court St., Sault Ste. Marie
Kooiker, Clarence.....300-306 Court St., Sault Ste. Marie
Mackie, Thos. B.....300 Court St., Sault Ste. Marie
Mc Bryde, Lyman M...416 Ashmun St., Sault Ste. Marie
Mertaugh, Wm. F.....104 W. Spruce St., Sault Ste. Marie
Montgomery, Benj. T...812 Ashmun St., Sault Ste. Marie
Porretta, Anthony C.....139 Arlington St., Sault Ste. Marie
Rhind, Earl S.....Sault Polyclinic, Sault Ste. Marie
Scott, Dale.....816 Ashmun St., Sault Ste. Marie
Solomon, Joseph A.....Mackinac Island
Thompson, Chas. F.....Drummond Island
Trapasso, Tony J.....816 Ashmun, Sault Ste. Marie
Venier, Anton G.....816 Ashmun St., Sault Ste. Marie
Wedding, Erling S.....336 Peck St., Sault Ste. Marie

CLINTON COUNTY MEDICAL SOCIETY (46)

Bennett, Geo. W.....203 W. Main St., Elsie
Cook, Bruno C.....Westphalia
Elliott, Bruce R.....Box 369, Ovid
Fillinger, Wells B. (L).....Ovid
Foo, Chas. T. (L).....1716 30th St. W., Bradenton, Fla.
Grost, James M.....110 Oakland St., St. Johns
Henthorn, Arthur C. (L).....Box 216, St. Johns
Luton, Frank E. (L).....Beaver Island, St. James
Mc Williams, Wm. B. (L)....701 S. Swegles St., St. Johns
Russell, Sherwood R.....104 N. Oakland St., St. Johns
Scott, James S.....Dewitt
Sheline, Victor L.....Medical Center, Ithaca
Slagh, Earl M.....Elsie
Smith, Franklin W.....105 S. Ottawa St., St. Johns
Stephenson, Wesley F.....510 E. Walker St., St. Johns
Stoller, Paul F.....St. Johns

DELTA-SCHOOLCRAFT COUNTY MEDICAL SOCIETY (50)

Anderson, Francis C.....218 S. 10th St., Escanaba
Bernier, A. Barroso.....547 Michigan Ave., Manistique
Bash, Theodore L.....Bark River
Benson, Gilbert W. (A).....Ludington St., Escanaba
Boyce, Donald H.....1107 Ludington St., Escanaba
Cretens, Mary (A).....Delta Menominee Health Dept., Escanaba
Dehlin, James R.....8 S. 11th St., Gladstone
Fitch, Donald N.....804 Ludington St., Escanaba
Fyvie, James H.....202 S. Cedar St., Manistique
Groos, Harold Q.....1015 S. 1st Ave., Escanaba
Groos, Louis P.....1015 S. 1st Ave., Escanaba
Hockstad, Raymond.....804 Ludington St., Escanaba
Hult, Otto S.....1005 Delta Ave., Gladstone
Jenke, Albert.....Bark River
Le Mire, Donald F.....1104 S. First Ave., Escanaba
Le Mire, William A.....1106 First Ave. S., Escanaba
Lindquist, Norman L.....205 S. Tenth St., Escanaba
Maniaci, Geo.....8 S. 11th St., Gladstone
Mc Inerney, Thos. A.....1221 Ludington St., Escanaba
Miller, Albert H. (L).....904 Wisconsin, Gladstone
Olson, Carl J.....8 S. 11th St., Gladstone
Ryde, Robt E.....1221 Ludington, Escanaba
Theisen, Nikolaus J.....St. Francis Hospital, Escanaba
Waters, Duane L.....200 S. Cedar St., Manistique
Wehner, Merle E.....131 River St., Manistique
Whipple, Arno.....117 N. 22nd St., Escanaba

DICKINSON-IRON COUNTY MEDICAL SOCIETY (54)

Addison, Earl R.....412 Superior Ave., Crystal Falls
Alexander, Wm. H.....411 East C St., Iron Mountain
Anderson, Donald T.....408 Hamilton Ave., Kingsford
Boyce, George H. (L).....First Natl. Bank Bldg., Iron Mountain
Carlson, Ralph E.....500 Stephenson Ave., Iron Mountain
Cecconi, R. D.....Commercial Bank Bldg., Iron Mountain
Cooper, Chas. A.....Box 542, Stambaugh
Gladstone, Wm. R., Jr.....804 Main St., Norway
Hayes, Willard N.....720 N. Main St., Norway
Huron, Willis H.....106 West B St., Iron Mountain
Irvine, Lionel E.....Box 438, Iron River
Jacobs, Donald J.....Ochiette Bldg., Iron Mountain
Kofmehl, Wm. J.....Stambaugh
Mc Eachran, Hugh D.....500 Stephenson Ave., Iron Mountain
Nora, James C.....15 8th Ave., Iron River
Palm, E. Theodore.....4704-14th Ave. S., Minneapolis 7, Minn.
Pieper, Ernest.....Iron Mountain
Retallack, Russell C.....326 W. Genessee St., Iron River
Schmutzler, Walter A.....373 Woodward St., Iron Mountain
Schroeder, John M.....Khoury Bldg., Iron Mountain
Smith, Donald R.....Box 471, Iron Mountain
Steinke, Chas. G.....517 Stephenson Ave., Iron Mountain
Stelle, Robert E.....412 Superior, Crystal Falls

EATON COUNTY MEDICAL SOCIETY (58)

Arner, Fred L. (L).....Bellevue
Brown, Byron P.....339 S. Cochran, Charlotte
Carothers, Danl. J.....315 S. Cochran, Charlotte
De Land, C. Le Roy.....Olivet
Engle, Paul H. (A).....Olivet
Erhard, O. Stewart.....301 Rancho, Eaton Rapids
Garlock, Fred C.....406 E. Jefferson St., Grand Ledge
Hannah, Harry W.....Box 697, Loma Linda, Calif.
Harrod, Gordon R.....Grand Ledge
Landick, Robt. E., Jr. (A).....Rt. 1, Charlotte
Matthews, R. W.....236 S. Main St., Charlotte
Meinke, Albert H., Jr.....702 S. Main, Eaton Rapids
Myers, Albert W.....Potterville
Riley, Jos. L.....201 S. Cochran St., Charlotte
Robinson, S. R.....1140 Willow St., Grand Ledge
Sevener, Lester G.....236 S. Main St., Charlotte
Sherman, Eber B.....210 Broad St., Eaton Rapids
Van Ark, Bert.....511 Hale, Eaton Rapids
Van Ark, Herman F.....Eaton Rapids
Willits, Clayton O.....127 Upland, Charlotte

GENESEE COUNTY MEDICAL SOCIETY (62)

Abbott, R. Roderick.....3516 Lynn St., Flint
Adams, Albert C.....G 7194 E. Court St., Davison
Adams, Burnell H.....609 S. Lynch St., Flint 3
Adams, Chester H.....410 S. Ballenger Hwy., Flint 4
Anderson, Harley H.....11820 N. Saginaw, Mt. Morris
Anderson, John L.....2765 Flushing Rd., Flint 4
Anderson, Robt. E.....420 S. Ballenger Hwy., Flint
Andrews, Nelson A. C.....310 E. Main St., Flushing
Anthony, Geo. E. R.....1015 Detroit St., Flint 4

Baird, W. Claire.....2765 Flushing Rd., Flint
Bald, Fredk. W.....420 S. Ballenger, Flint 3
Barbour, David A.....5369 Briarcrest, Flint
Barbour, Fleming A.....2015 Lincoln Dr., Flint 3
Baske, Franklin W.....923 Maxine St., Flint 3
Basualdo, Carlos A. E. (A)..511 Kingsley St., Ann Arbor
Batdorf, John W.....1925 Park Forest Dr., Flint
Batdorf, Joseph T.....11325 S. Saginaw, Grand Blanc
Bateman, Lawrence G.....1928 Lewis St., Flint 6
Beck, Douglass R.....1450 Country View Lane, Flint 7
Becker, Eugene B.....2765 Flushing Rd., Flint 4
Benkert, Jack.....6211 Lake Forest Dr., Grand Blanc
Benson, John C.....402 W. 2nd St., Flint 3
Berman, Harry.....3309 Fenton Rd., Flint 7
Berner, Gerald P.....5205 Susan, Flint 5
Bernstein, Eli N.....311 E. Court St., Flint
Best, J. A.....3801 Clio Rd., Flint 4
Beyer, Geo. D.....G 3337 W. Vienna, Clio
Bishop, Don L.....2226 Detroit St., Flint 5
Bogart, Leon M. (L).....503 National Bldg., Flint
Bolduc, Gregoire.....7006 Cranwood Dr., Flint
Boles, Wm. P. (L).....714 Beach St., Flint 3
Bosker, Donald.....1620 N. Franklin, Flint 3
Bota, Robert A.....602 Kensington Ave., Flint
Bradley, Robt M.....1112 Mott Fnd. Bldg., Flint 2
Brain, Roy G.....460 S. Saginaw St., Flint 3
Branch, Hira E.....1014 Woodside Dr., Flint 3
Brasie, Donald R. (R).....310 Josephine St., Flint 4
Briggs, Guy D. (L).....224 E. Court St., Flint 3
Brown, Clarence A.....1601 Woodlawn Pk. Dr., Flint 7
Bryant, Donald R.....621 Mott Fdn. Bldg., Flint
Burkett, Leslie V.....121 E. 7th St., Flint 3

Caster, Elisha W. (L)....24711 Ridgedale St., Oak Park
Chambers, Myrton S.....3402 Westwood Pkwy., Flint 3
Chase, Wm. D.....1318 N. Ballenger Hwy., Flint 4
Clark, Robt. L.....1301 Flushing Rd., Flint 4
Collins, James I.....G 1128 N. Dye Rd., Flint
Colwell, Clifford W.....328 S. Saginaw St., Flint 3
Conover, Geo. V.....207 Genesee Bank Bldg., Flint 2
Conover, McClellan B.....724 East St., Flint 3
Cook, Frank W.....Genesee Bank Bldg., Flint
Cook, Henry (L).....709 Genesee Bank Bldg., Flint 2
Cook, John L.....3942 Western Rd., Flint 7
Cookingham, Cory E.....208 Medical Arts Bldg., Flint
Coriasso, Louis B.....1515 W. Atherton Rd., Flint 4
Covert, Floyd L. (L).....116 Lord St., Gaines
Coyne, K. M.....2765 Flushing Rd., Flint
Craig, William G.....G 3176 W. Court St., Flint
Cross, Robert L.....6029 Marja, Flint
Curry, Geo. J. (L).....346 S. Saginaw St., Flint 3
Cutler, G. Campbell.....420 S. Ballenger, Flint 4

Davis, Robt C.....G 3029 Flushing Rd., Flint 4
Dawson, Ralph E.....111 Med. Arts Bldg., Flint 4
Day, John Murray.....2765 Flushing Rd., Flint 4
Delzingro, Nicholas (L).....328 Main St., Davison
Dettman, Carlton K.....Nanita Dr., Montrose
Dickstein, Bernard.....605 National Bldg., Flint 3
Dismond, Samuel R.....1402 S. Saginaw St., Flint
Dodds, Fredk. E. (L).....1336 Lewis St., Flint 6
Dodds, Max E.....625 S. Grand Traverse, Flint
Dooley, James F.....1609 Brookwood Dr., Flint 3
Dorsey, Philip W.....2765 Flushing Rd., Flint 4
Drewyer, Glenn E.....2001 Colchester, Flint 3
Dwyer, William F.....625 S. Grand Traverse, Flint
Dykewicz, Richard A.....2768 Flushing Rd., Flint 4

Eaton, Wayne L.....633 Mott Fdn. Bldg., Flint
Eichhorn, E. M.....2765 Flushing Rd., Flint 4
Eickhorst, Thos. N.....2765 Flushing Rd., Flint 4
Elliott, Hardie B.....503 S. Saginaw St., Flint 3
Engelman, Raymond M.....114 Med. Arts Bldg., Flint 4
Ettinger, Ralph D.....Box 1295, Winter Haven, Fla.

Fan, Q. C.....2002 E. Court St., Flint
Farah, Ben S.....2765 Flushing Rd., Flint 4
Farhat, Maynard M.....505 W. Court St., Flint
Fee, Manson G.....108 E. Kearsley St., Flint 3
Ferris, James W.....426 N. State St., Davison
Finkelstein, Theo.....1415 Broadway Blvd., Flint 6
Forrer, Graydon R.....112 Med. Arts Bldg., Flint 3
Fuller, Harvey T. (R).....820 Genesee St., Mt. Morris

Gelenger, Stephen M.....2125 Detroit St., Flint 5
Gilbert, David H. (A)....39FA 1st Msl. Bn. A.P.O. 165, New York, N. Y.
Goering, George R. (L).....2601 Norbert, Flint
Goetz, Margarete M. (A)....420 Genesee Bk. Bldg., Flint
Goetz, Rudolph.....1221 Church St., Flint
Golden, Evelyn.....218 E. Court St., Flint
Golden, H. Maxwell.....218 E. Court St., Flint 3
Goodfellow, Benj. T. (L)....141 Davis Lake Rd., Lapeer
Gorne, Saul S.....619 Clifford St., Flint 3
Griffin, Ernest P., Jr.....1505 Arrow Lane, Flint 7
Grover, Harold F.....601 S. Saginaw St., Flint 3
Guile, Gurdon S.....1621 Dupont St., Flint 4
Gumpper, C. R.....4437 Morrish Rd., Swartz Creek
Gundry, Geo. L. (L).....Grand Blanc
Gutow, Isadore H.....2765 Flushing Rd., Flint 4
Gutow, I. I.....726 Church St., Flint
Gutowitz, Erwin.....420 S. Ballenger Hwy., Flint
Guyon, Jos. F.....302 W. Pierson Rd., Flint 5
Guyon, Mary A. W.....302 W. Pierson Rd., Flint 5

Hackley, Richard D.....3942 Western Rd., Flint
Hague, Robt. F.....210 E. Court St., Flint 3
Hallitt, John Wm.....102 Medical Arts Bldg., Flint
Harper, Robt. H.....713 Thomson St., Flint 3
Harris, Bernard J.....1750 Lynbrook, Flint
Harris, Donald R.....2427 Welch Blvd., Flint
Hauser, Fredk. V.....1015 Mott Fndn. Bldg., Flint 2
Hawkins, James E.....4618 Robert St., Flint
Heinemann, Herman H.....1809 Greenbriar Lane, Flint 7
Helcher, Phyllis O.....G5303 Flushing Rd., Flushing
Hennessy, Charles R.....517 Mott Fndn. Bldg., Flint
Hing, N. Wm. (A).....326 Stockdale St., Flint 5
Hiscock, Harold H.....503 S. Saginaw St., Flint 3
Hockman, Thomas A.....11125 Old Bridge Rd., Grand Blanc
Hodges, Frank V.....Hurley Hospital, Flint 2
Hollis, John W.....Fisher Body Div., Grand Blanc
Hooper, Virgil R.....2007 Fenmore, Flint
House, Robert J.....3133 Mackin Rd., Flint
Hubbard, Wm. B.....1205 Maxine St., Flint 3
Hubbard, Wm. C.....302 Paterson Bldg., Flint
Hufton, Wilfrid L.....2765 Flushing Rd., Flint 4
Hunt, Richard J.....6259 Lake Forest Dr., Grand Blanc
Hurd, Clayton E.....205 Lincoln St., Fenton

Irish, Lawrence R.....2733 Crestwood, Flint

Jaarsma, Raymond A.....11528 S. Saginaw, Grand Blanc
Jacoby, John S.....4300 S. Saginaw St., Flint
James, Robt. E.....1515 W. Atherton, Flint
Johnson, A. H., Jr.....3219 North St., Flint 5
Johnson, Frank D.....625 S. Grand Traverse, Flint
Johnson, Raymond E.....5173 W. Reid Rd., Swartz Creek
Jordan, Paul H.....1125 Jordan Lane, R. 2., Grand Blanc 8
Judd, Alvin E.....1620 N. Franklin, Flint 6

Karr, Paul H. (M).....6111 Camden, Omaha, Neb.
Kaufman, Lewis D.....4002 N. Saginaw St., Flint 5
Kelly, James E.....420 S. Ballenger, Flint
Kimbrough, C. B.....1402 S. Saginaw St., Flint 3

Kirsten, Walter T.....809 S. Ballenger, Flint
Kitto, Harold J.....902 Stockdale, Flint
Kline, O. F.....2765 Flushing Rd., Flint 4
Knapp, Wm. D.....503 S. Saginaw St., Flint 3
Koop, Chester S.....2503 Detroit St., Flint 5
Kretchmar, Arthur H.....625 S. Grand Traverse, Flint
Kurtz, John J. (L).....601 S. Saginaw St., Flint 3

Laird, James I.....12010 Kipp Rd., Goodrich
Leach, J. Leonidas.....3007 Industrial Ave., Flint
LeMieux, Leslie L.....701 W. Dayton St., Flint 4
Levine, Mark C.....111 Med. Arts Bldg., Flint
Lewis, Thos. E.....3520 Richfield Rd., Flint 6
Lightfoot, Arthur S.....4500 Detroit St., Flint
Limbach, David R.....900 Begole St., Flint 2
Lindman, Thomas C.....508 Fremont St., Flint
Livesay, Jackson E.....503 S. Saginaw St., Flint 3
Lundeen, Richard M.....3393 Clio, Flint
Lusk, John A.....9233 W. Davison Rd., Davison
Lyttle, Sydney N.....503 S. Saginaw St., Flint 3

MacGregor, Delbert M.....701 W. Dayton St., Flint 4
MacKenzie, J. W., Jr.....4437 Morrish Rd., Swartz Creek
Macksood, Jos. A.....3169 W. Pierson Rd., Flint 4
Macksood, William E.....3169 W. Pierson Rd., Flint
MacPhail, Albert A.....1819 Park Forest Dr., Flint
Mangelsdorf, C. H.....4122 Brownsell, Flint
Manwaring, John T.....565 Welch Blvd., Flint 3
Markunas, Paul J.....4002 N. Saginaw St., Flint
Martin, James A.....822 S. Leroy, Fenton
Mathias, Berton J.....1301 Flushing Rd., Flint 4
McAlindon, J. D.....1601 Euclid, Flint
McClellan, Junius W.....Buick Motor Division, Flint 7
McGarry, Roy A. (L).....601 S. Saginaw St., Flint 3
McGregor, Allan R.....G 3337 W. Vienna Rd., Clio
McLeod, Kenneth W. A.....2765 Flushing Road, Flint 4
McMurray, Richard J.....2765 Flushing Rd., Flint
McTaggart, David.....625 S. Grand Traverse, Flint
Mendes, Peter C. (A).....11117 116th St., Edmonton, Alberta, Can.
Mendrek, H. H.....1634 Mott Fndn. Bldg., Flint 2
Michael, Sidney R.....922 Welch Blvd., Flint 4
Michels, Robt. M. (A).....409 McKinley Rd., Flushing
Michelson, Richard B.....2014 Robt. T. Longway, Flint 3
Miller, Loren E.....2645 Corunna Rd., Flint 3
Miltich, Anthony J.....915 S. Grand Traverse, Flint 3
Moeller, Jan C.....1805 Windsor Lane, Flint
Moore, Glenn E.....323 W. Second, Flint 3
Moore, Wesley P. (A).....802 Tilden, Flint 5
Morin, Paul.....1968 Miller Rd., Flint
Morrison, Wm. H.....11610 Hazel St., Grand Blanc
Morrissey, Vaughn H.....101 Stockdale St., Flint 4
Mosier, Edward C.....115 Lake St., Otisville
Murphy, E. Grant.....1825 Chelsea Circle, Flint 3
Newman, Harry S.....218 E. Court St., Flint
Nicholls, Wm. W.....806 W. Sixth Ave., Flint 3
Nitz, Donald A.....1515 W. Atherton Rd., Flint

Odle, Ira D. (L).....201 Welch Blvd., Flint 4
Oldt, Mary Ruth.....602 S. Lynch St., Flint 3
Orr, John W. (L).....Orrs Pt., Lk. Fenton, Fenton
Osher, Seymour L.....315 E. Court St., Flint 3

Parliament, Burt A.....314 Ferndale Pl., Flint 3
Pfeifer, Archibald C. (L) 12205 N. Saginaw, Mt. Morris
Phelps, Lynn A.....10122 Janaroy Ct., Goodrich
Phillips, A. F.....X-Ray Dept. Hurley Hosp., Flint
Pickering, Woodrow H.....1602 Ballenger Hwy., Flint 4
Pike, Wallace W.....7514 Miller Rd., Swartz Creek
Platt, Alice Lee,.....1430 Eldorado Dr., Flint
Portney, Jack E.....725 Stevens St., Flint 3
Pougnet, W. D.....6155 Mapleridge, Flint
Pratz, Oliver C.....1303 Detroit St., Flint 4
Preston, Otto J.....300 N. Chevrolet Ave., Flint 2
Price, Jack R.....410 S. Ballenger Hwy., Flint
Prior, Richard W.....1266 S. LeRoy, Fenton
Purcell, F. L.....Ternstedt Plant, Flint 5
Quin, John, Jr.....2765 Flushing Rd., Flint 4

Ragan, Russell M.....2768 Flushing Rd., Flint
Rapport, Richard L.....503 S. Saginaw, Flint 3
Rathburn, Robert J.....1501 Flushing Rd., Flint
Rawling, John C.....115 Med. Arts Bldg., Flint 4
Rawlings, J. Mott.....1601 Neome Dr., Flint 3
Reid, John H.....1301 Flushing Rd., Flint 4
Reye, George H.....2765 Flushing Rd., Flint
Rieth, Geo. F.....1406 Davison St., Flint 6
Roberts, Floyd A. (L).....327 Sheffield, Apt. 281, Flint 3
Roth, F. Dale.....1432 Mott Bldg., Flint
Rowe, John B.....653 Saginaw St., Flint 3
Rulney, Max.....2765 Flushing Road, Flint 4
Rundles, Walter Z.....500 Grand Traverse St., Flint 3
Rundles, Walter Z., Jr. 500 Grand Traverse St., Flint 3

Sandberg, Russell G.....2030 Pierce St., Flint 3
Sande, C. W. (A).....Northwood, No. Dak.
Saunders, Jack (A).....20 Doctors Lane, King City, Ont., Can.
Scavarda, Chas. J.....1106 Maxine, Flint
Schiff, Benton A.....323 W. 2nd St., Flint 3
Schmidlin, Robt. W.....3710 Davison Rd., Flint 6
Schreiber, E. Oskar.....2765 Flushing Road, Flint 4
Schroeder, Paul E.....907 Welch Blvd., Flint 4
Schultz, J. Stanley.....3327 Fleming Rd., Flint 4
Schwartz, John M.....1300 N. Dort Hwy., Flint
Schwarz, Heinz H.....1430 Eldorado, Flint
Scott, Robt. D. (L).....1215 Detroit St., Flint 4
Seven, Phillip G.....2301 Cummings, Flint
Seymour, Geo. D.....G7237 N. Saginaw, Mt. Morris
Shantz, Leighton O.....1497 Country View Lane, Flint 3
Sheeran, Danl. H.....610 S. Vernon Ave., Flint 3
Sherwood, Frederick.....2765 Flushing Rd., Flint 4
Shipman, Charles W.....Warren State Hosp., Warren, Penna.
Simoni, Lewis E.....3210 S. Dort Hgwy., Flint 7
Sirna, Anthony R.....2709 Thomas St., Flint 4
Smith, Eugene C.....503 S. Saginaw St., Flint 4
Smith, Harold O.....1952 Miller Rd., Flint 3
Smith, Sidney E.....625 S. Grand Traverse, Flint
Sniderman, Benj. F.....727 Beach St., Flint 3
Snyder, Chas. E.....Swartz Creek
Solik, A. E. (M)
Sorkin, Morris L.....718 Beach St., Flint 2
Sorkin, Saml. S.....718 Beach St., Flint 2
Sparks, Harvey V.....2765 Flushing Rd., Flint 4
Steffe, Ralph S.....2765 Flushing Rd., Flint 4
Steinman, Floyd H.....503 S. Saginaw St., Flint 2
Stevens, Philip K.....1116 Mott Fndn. Bldg., Flint
Stevenson, Wm. W. (L).....108 E. Kearsley St., Flint 3
Streat, Rudolph W. (L).....218 E. 8th St., Flint 3
Stroup, Clayton K.....2002 E. Court St., Flint 3
Sullivan, M. R.....1510 Forest Hill, Flint
Sutherland, James K.....402 E. 3rd St., Flint 3
Sutton, Geo. D. (L).....303 W. Court St., Flint 3

Tauscher, John W.....2016 R. T. Longway Blvd., Flint
Theuerle, Walter I.....3101 N. Saginaw St., Flint 5
Thompson, Charles A.....4211 Comstock St., Flint 4
Thompson, Jack W.....2702 Flushing Rd., Flint 4
Thoms, Peter S.....1279 W. Coldwater Rd., Flint
Thorburn, Grant (L).....Box 387, Waynesboro, Pa.
Tofteland, Elmer H.....2765 Flushing Rd., Flint 4
Tower, Rita B. (L).....2801 S. Dort Hwy., Flint 7
Turcke, Allen F.....5717 Marja St., Flint 5
Turner, Merald G.....601 S. Saginaw St., Flint 2
Tuuri, Arthur L.....Mott Children Clinic, Flint
Urich, Vernon.....1315 Mott Fndn. Bldg., Flint 2

Van Duyne, Fredk. W.....2849 Miller Rd., Flint
Van Harn, Raymond S.....1651 Detroit St., Flint 5
Varney, Howard L.....724 East St., Flint
Vaughan, Edgar J.....Linden
Vergith, L. William.....399 Contant, Flushing
Wade, Franklin V.....1121 Mott Fndn. Bldg., Flint
Walcott, Carver G.....201 E. Carolina, Fenton
Ward, Nell M. (L).....503 S. Saginaw St., Flint 3
Weber, Robt. M.....3710 Davison Rd., Flint 6
Webster, Robt. M. (A).....5 Lee St., Newman, Ga.
Wentworth, John E.....420 S. Ballenger, Flint 4
Werness, Inga W. (L).....220 East Fourth St., Flint
Wheeler, J. D.....2470 Nolen, Flint

White, Carl H.....106 River St., Fenton
White, Frank T.....5492 Lapeer Rd., Flint
Willard, Robt. H.....718 Beach St., Flint 3
Williams, T. Wendell.....5003 N. Saginaw, Flint
Williams, Wm. S. (L).....5216 S. Genesee, Grand Blanc
Willis, Robert E.....6606 N. Saginaw St., Flint
Willoughby, L. L. (L)....1127 S. Water St., Marine City
Wills, Thos. N. (R).....Chicaugoan Lake, Crystal Falls
Wolcott, Nan D.....7506 Lapeer Rd., Davison
Woodsides, K T.....7343 Flushing Rd., Flushing
Wright, Donald R.....326 W. Court St., Flint
Wynia, Robert E. (A).....2301 12th Ave. South, Great Falls, Mont.
Zeis, Myron G.....718 Beach St., Flint 2

GOGEBIC COUNTY MEDICAL SOCIETY (66)

Albert, Saml. G.....103 Suffolk St., Ironwood
Davidson, Donald L.....200 S. Sophie St., Bessemer
Franck, John R., Jr.....401 Sunday Lake, Wakefield
Gallo, Bella.....Newport Clinic, Ironwood
Gertz, Michael A.....109 E. Aurora St., Ironwood
Gorilla, Allen C.....210 Suffolk St., Ironwood
Harrington, Rex R., Jr.....104 E. Ridge St., Ironwood
Lieberthal, M. J. (L).....P.O. Box 632, Ironwood
Lieberthal, Paul R.....Box 632, Ironwood
Medford, Lester.....306 Sunday Lake St., Wakefield
Murphy, Percy J.....Seaman Bldg., Ironwood
Santini, Florian J.....109 E. Aurora St., Ironwood
Wacek, William H.....809 Sunset Road, Ironwood

GRAND TRAVERSE-LEELANAU-BENZIE COUNTY MEDICAL SOCIETY (70)

Beall, John G.....1105 E. Front St., Traverse City
Bolan, Ellis J.....Suttons Bay
Brownson, Kneale M.....116 Cass St., Traverse City
Bushong, Benj. B.....116 Cass St., Traverse City
Cajigas, Tomas R.....J. D. Munson Hosp., Traverse City
Campbell, Thomas D. Box C, Traverse City
Christie, Joseph Northport
Clark, Oswald V.....Ramsdell Rd., Traverse City
Cline, Theodore N.....438 W. Front St., Traverse City
Cline, Warren W.....438 W. Front, Traverse City
Coleman, John F.....10680 Peninsula Dr., Traverse City
Curran, Cyril J.....Box C, Traverse City
Dundon, Arthur F.....Box C, Traverse City
Edmonds, W. T.....Munson Hosp., Traverse City
Ellis, Claude I.....Suttons Bay
Ferguson, John T.....Box C. Traverse City
Fiebing, Jack A.....P.O. Box 283, Traverse City
Fishbeck, Wm. A.....1021 E. 8th St., Traverse City
Goodrich, Dwight (R)....601 W. Front St., Traverse City
Haberlein, Chas. R.....1100 Sixth St., Traverse City
Hall, James W.....1100 Sixth St., Traverse City
Hamilton, Earl E.....530 S. Union St., Traverse City
Herkner, Mildred L.....119 Barlow St., Traverse City
Hubbell, Reader J.....228 S. Madison, Traverse City
Huene, Nevin.....110 E. Front St., Traverse City
Huston, R. R. (L).....Elk Rapids
Kamp, Robt. L.....Beulah
Kaufman, James N.....427½ Main St., Frankfort
Kitti, Wm. W.....Kalkaska
Lemen, Charles E.....110 S. Madison, Traverse City
Lieding, Keith G.....7844 Peninsula Dr., Traverse City
Lossman, Robt. T.....J. Decker Munson Hosp., Traverse City
Magill, Arthur L.....11766 W. Bay Shore Dr., Traverse City
McClay, Adam C.....6330 Pen Dr., Traverse City
McKenney, J. Paul.....721 Sixth St., Traverse City
Michael, Stanley L.....335 Davis St., Traverse City
Milliken, John G.....224 Circle Dr., Traverse City
Nickels, Mervyn M.....Box C, Traverse City
Norconk, Alonzo A.....Empire
Olsen, William R.....1100 Sixth St., Traverse City
Peterson, Wm. D.....876 E. Front St., Traverse City
Pike, Donald G. (A).....1705 East West Hiway, Silver Springs, Md.
Power, Frank H.....116 Cass St., Traverse City
Salon, Dayton D.....108 E. Front St., Traverse City
Schroeder, Dwight M. Northport
Sheffer, Marcus B. (A).....228 West Brighton
Sladek, Edward F.....123 E. Front St., Traverse City
Sommerness, M. Duane.....Box C, Traverse City
Sorum, F. T.....Box C, Traverse City
Spencer, John R.....1124 E. Front St., Traverse City
Steffey, Jos. C.....116 Cass Street, Traverse City
Stokes, G. Edward.....1100 Sixth St., Traverse City
Swartz, Fred G. (L).....612 Sixth St., Traverse City
Sweeney, Bernard J.....1100 Sixth St., Traverse City
Thacker, Fredk. R.....Front St., Frankfort
Thirlby, Edwin L. (L).....116 Cass St., Traverse City
Thirlby, Richard L.....228 S. Madison, Traverse City
Trautman, Fredk. D.....Frankfort
Wagener, Creighton A.....1100 Sixth St., Traverse City
Weih, Jack E.....1105 E. Front St., Traverse City
Weitz, Harry L. Munson Hosp., Traverse City
Wilcox, Paul H.....333 Sixth St., Traverse City
Wiley, Philip K.....116 Cass St., Traverse City
Williams, Chas. R.....416 Sixth St., Traverse City
Willoughby, Gordon W.....408 Main St., Frankfort
Wright J. K., Jr.....1105 E. Front St., Traverse City
Young, John Harley.....Box C, Traverse City
Young, Lloyd B.....Route 2, Suttons Bay
Zielke, Irwin H.....106 S. Madison, Traverse City
Zimmerman, Jos. G.....102 W. Front St., Traverse City

GRATIOT-ISABELLA-CLARE COUNTY MEDICAL SOCIETY (74)

Aldrich, Alfred L.....Ithaca
Barstow, Donald K.....215 W. Saginaw, St. Louis
Bauer, A. Robert, Jr.....412 E. Broadway, Mt. Pleasant
Becker, Myron G.....Edmore
Bedo, Andrew V.....802 Gordon, Mt. Pleasant
Bergin, Jos. H.....112 E. Superior, Alma
Binning, Griffith.....915 S. College, Mt. Pleasant
Brenner, E. J.....Central Mich. Com. Hosp., Mt. Pleasant
Budge, Melvin J. (L).....1035 Jefferson, Ithaca
Burt, Clarence E.....110 S. Pine River, Ithaca
Burt, Loren G.....510 Prospect St., Alma
Chamberlain, Ray W.....608 E. Chippewa, Mt. Pleasant
Chamichian, Souren L.....117 S. College, Mt. Pleasant
Davis, Lionel L.....314 S. Brown St., Mt. Pleasant
Dunlop, Donald.....301 East Fourth St., Clare
Gervin, Irfan S.....231 East End St., Alma
Graham, Bernard J.....510 Prospect Ave., Alma
Haddad, T. E.....207 N. Franklin St., Mt. Pleasant
Hammerberg, Kuno.....622 McEwan, Clare
Harrigan, Wm. L.....412 E. Broadway, Mt. Pleasant

Hedges, Frank W.....Post Office, Edmore
Hersee, Wm. E.....306 S. College, Mt. Pleasant
Hobbs, A. Deane (R).....Box 3233 Florence Vill., A Station, Winter Haven, Fla.
Hoogerland, C. L.....226 N. State St., Alma
Hyslop, Leland F.....205 S. College Ave., Mt. Pleasant
Johnson, Frank D.....806 E. Bellows, Mt. Pleasant
Johnson, Philip R.....206 S. College Ave., Mt. Pleasant
Johnson, Robert B.....120 S. St. Johns St., Ithaca
Juhnke, LeRoy W.....314 S. Brown St., Mt. Pleasant
Kim, S. J.....704 Crapo, Mt. Pleasant
Linn, Michael R.....Gratiot Med. Arts Bldg., Alma
Lusis, Alexsandrs....St. Home & Tr. School, Mt. Pleasant
McArthur, Stewart C.....Box 32, Rosebush
McCoy, F. E.....914 S. Kinney, Mt. Pleasant
Oldham, Earle S.....Breckenridge
Pease, Horace B.....Health Unit CMU, Mt. Pleasant
Ringer, Paul H., Jr.....314 S. Brown St., Mt. Pleasant
Rottschaefer, John L.....3580 Northlawn Pk., Alma
Sanders, Jack F.....Mich. Masonic Home, Alma
Scott, Lincoln B., Jr.....417 S. College, Mt. Pleasant
Silvert, Pasche P.....Vestaburg
Soriano, D. A.....218 W. High St., Mt. Pleasant
Veldhuis, Andrew H.....801 Gordon Rd., Mt. Pleasant
Von Lackum, L. F.....535 Prospect Blvd., Waterloo
Waggoner, Richard L.....120 N. Center St., St. Louis
Wallman, C. Harry.....901 State St., Alma
Wickert, Leo R.....1001 Watson Rd., Mt. Pleasant
Wilcox, Rex A.....525 State St., Alma
Wilson, Earl C.....Harrison
Wolfe, Kenneth P.....510 Prospect Ave., Alma
Wood, Cornelius B.....207 N. Franklin St. Mt. Pleasant
Wood, John M.....1300 S. Watson Rd., Mt. Pleasant

HILLSDALE COUNTY MEDICAL SOCIETY (78)

Bates, Morton P.....110 S. Manning, Hillsdale, Mich
Davis, William B.....40 E. Bacon, Hillsdale
Day, Luther W.....Grosvener Bnk. Bldg., Jonesville
Gates, Jon H.....379 S. Broad, Hillsdale
Hanke, Geo. R. (L).....Osseo
Hodge, Chas. L.....Reading
MacNeal, John A.....379 S. Broad, Hillsdale
Mattson, H. Frazyer.....32 S. Broad St., Hillsdale
Peterson, Carl A.....32 Broad St., Hillsdale
Reigle, Frederick C.....Litchfield
Sawyer, Walter W.....61 N. Howell St., Hillsdale
Smith, Clark B.....379 S. Broad St., Hillsdale
Stein, Arthur J.....144 Budlong St., Hillsdale
Strom, Arthur W.....32 S. Broad St., Hillsdale
Trapp, Donald G.....32 S. Broad St., Hillsdale
Wiggins, Ira W.....Jonesville

HOUGHTON-BARAGA-KEWEENAW COUNTY MEDICAL SOCIETY (82)

Albright, John G.....220 Iroquois St., Laurium
Aldrich, Addison B.....325 Harris Ave., Hancock
Aldrich, Leonard C.....301 Quincy St., Hancock
Hillmer, Raymond E. (L).....Painsdale
Hosking, Fredk. S.....322 Calumet St., Lake Linden
Janis, Anton J.....208 Quincy St., Hancock
Kolb, Fredk. E.....128 Calumet Ave., Calumet
LaBine, Alfred (L).....Masonic Bldg., Houghton
Larson, Forrest W.....322 Shelden, Houghton
Lepisto, Victor E.....238 Quincy St., Hancock
Levin, Simon (L).....1209 College Ave., Houghton
Meier, Maurice D.....1033 Mine St., Calumet
Parker, Thomas M.....St. Joseph Hospital, Hancock
Potter, Earl C. (R).....28641 Piping Rock Rd., Sun City, Calif.
Repola, Kenneth L.....401 Isle Royale St., Laurium
Roche, Andrew M.....221 5th St., Calumet
Rowe, Kenneth E.....107½ Calumet Ave., Calumet
Sandell, Samuel T.....210 Center St., Hancock
Sloan, Paul S.....609 Sheldon Ave., Houghton
Stallard, C. W., Jr.....305 Tamarack St., Laurium
Stroube, John A.....522 W. Third, L'Anse
Williams, Marshall S.....St. Josephs Hospital, Hancock

HURON COUNTY MEDICAL SOCIETY (86)

Dixon, Ralph C.....Box 77, Pigeon
Elliott, Chas. S.....Pigeon
Gettel, Roy R.....Bad Axe
Herrington, C. Clark.....117 S. Port Crescent, Bad Axe
Herrington, Chas. I.....Bad Axe
Herrington, K. B.....317 Port Crescent, Bad Axe
Herrington, Willet J.....Bad Axe
Oakes, Chas. W.....Harbor Beach
Scheurer, Clare A. Pigeon
Sidagis, Joseph.....6 W. Main St., Sebewaing
Sorensen, Maurice G.....P.O. Box, Elkton
Steinhardt, Edward E.....Box 15, Elkton
Thompson, David H.....117 S. Port Crescent, Bad Axe
Turner, Phillip R.....321 S. Fourth St., Harbor Beach
Wible, Chas. F., Jr.....Sebewaing
Willits, Robert A.....193 N. Main St., Elkton

INGHAM COUNTY MEDICAL SOCIETY (90)

Agate, Geo. H.....Mich. Dept. of Hlth., Lansing 4
Aiken, Donald J.....Grandview & Grand Rv., Okemos
Alexander, Reuben G.....301 Seymour Ave., Lansing 15
Allen, Robert E., Jr...202 Medical Arts Bldg., Lansing 12
Altland, J. K.....Route 3, Box 178, Lansing
Altman, Harold (A) 124 N. Magnolia Ave., Lansing 12
Asselin, David C.....315 Medical Arts Bldg., Lansing 12
Badgley, Waldo O.....M. O. Box 756, Lansing 6
Baker, Thos. C.....624 N. Capitol Ave., Lansing
Balog, John F. (A).....1100 Weber Dr., Lansing 12
Bassett, Robert C.....214 Medical Arts Bldg., Lansing 12
Bates, Richard.....2909 E. Grand River, Lansing
Bauer, Theodore I.....810 Mich. Nat. Tower, Lansing
Beaubien, Mark S. (A).....1006 Wildwood Dr., East Lansing
Behn, Wm. C. (L).....535 S. Capitol Ave., Lansing
Behney, Charles A. (L).....Box 4256, Sand Jose Br., Bisbee, Ariz.
Bellinger, Ernest G. (L).....Masonic Home, Alma
Berden, Eleanor A.....2630 Libbie Drive, Lansing 17
Berens, Burdette M.....Kalkaska
Berge, Richard E. (A).....1618 S. Genesee, Lansing 15
Bergeon, Milton C.....302 S. Steele St., Mason
Bevez, Frank L.....3209 S. Cambridge Rd., Lansing
Bingham, B. Wayne.....1034 E. Saginaw, Lansing 6
Black, Chas. E.....112 W. Allegan, Lansing

Black, Gertrude C. K. 529 W. Grand River, Williamston
Blair, Thomas C.....316 Medical Arts Bldg., Lansing 12
Bleil, Eugene F.....112 Medical Arts Bldg., Lansing 12
Boylan, Rowan C.....Sparrow Hospital, Lansing
Bradford, Carl W.....301 Seymour, Lansing
Breakey, Robt. S. (R).....520 Westmorland, Lansing 15
Briggs, James.....2132 N. Cedar St., Holt
Brown, Fredk. W., Jr...831 N. Washington Ave., Lansing
Brown, Joseph C.....790 E. Columbia, Mason
Brubaker, Earl W...103 N. Washington Ave., Lansing 16
Bruegel, Oscar H. (L) 204 Birchwood Dr., Traverse City
Burhans, Robt. A.....810 Mich. Natl. Tower, Lansing
Burt, Emma G.....General Delivery, Agana, Guam
Cairns, Donald A.....136 W. Ash St., Mason
Calomeni, Anthony D.....309 Seymour Ave., Lansing 15
Carlson, Ralph G.....225 S. Waverly, Lansing 17
Carr, Earl I.....1915 Moores River Dr., Lansing 10
Caruso, Joseph A.....2909 E. Grand River, Lansing
Casey, Byron L.....202 M.A.C., East Lansing
Chaskes, Marian I. G.....210 E. Hillsdale, Lansing
Cheney, Wm. D.....Sparrow Hosp, X-Ray, Lansing
Chi Seong H. (A).....Ingham Medical Hosp., Lansing
Cipparone, Joseph R.....St. Lawrence Hosp., Lansing
Clark, Gaius D.....Oldsmobile Div. GMC, Lansing
Clark, Wm. E. (A).....809 E. Ash Street, Mason
Clinton, Geo. R. 618 S. Jefferson St., Mason
Clore, Forrest C.....2909 E. Grand River, Lansing
Combs, Robt. G.....1023 E. Michigan Ave., Lansing 12
Comstock, Howard C...2909 E. Grand River, Lansing 12
Cook, J. Maxwell.....209 N. Walnut St., Lansing
Cope, Henry E. (R).....605 Westmoreland, Lansing 15
Cordes, Jerome F.....2909 E. Grand River, Lansing
Corneliuson, G. B. Mich. Dept. of Health, Lansing 15
Cowan, John A.....825 Touraine, East Lansing
Cummings, Geo. D.....Mich. Dept. of Hlth., Lansing 4
Dale, Edward C.....Health Service MSU, East Lansing
Darling, Lewis H.....115 W. Hillsdale St., Lansing 15
Dawe, C. D.....1515 W. Mt. Hope Ave., Lansing
Denson, Andrew L. (A).....Northville State Hosp., Northville
DeVries, Corydon F.....320 Townsend St., Lansing 15
Dexter, M. J.....229 E. Maple, Mason
Drolett, Alfred J. (L)....1018 Prudden Bldg., Lansing 16
Drolett, Donald J.....2909 E. Grand River, Lansing
Drolett, Lawrence A.....3526 W. Saginaw St., Lansing 17
Dunkel, John F.....Edw. W. Sparrow Hosp., Lansing
Dunn, F. Mansel.....317 Medical Arts Bldg., Lansing 12
Ellis, Bertha W. (R).....Box 216, Port Blakely, Wash.
Ellis, C. Ward (L).....Box 216, Port Blakely, Wash.
Feeney, Kenneth J. 1908 Mich. Natl. Tower, Lansing 15
Ferrari, Fulvio (A).....St. Lawrence Hosp., Lansing
Feurig, James S.....321 Kensington, East Lansing
Finch, Russell L.....420 S. Walnut St., Lansing 33
Folkers, Leonard M.....234 Michigan Ave., East Lansing
Fortino, Silvio P.....2909 E. Grand River, Lansing
French, Horace L.....111 Medical Arts Bldg., Lansing 12
Fryer, Douglas H.....Mich. Dept. of Hlth., Lansing 4
Gage, David P.....Voca. Rehab., Box 1016, Lansing
George, Harry C.....335 Seymour St., Lansing 33
Ghannam, Rasem (A).....326 N. Ingalls, Ann Arbor
Goldner, Roy E.....1318 S. Washington, Lansing 10
Govons, Sidney R.....303 Medical Arts Bldg., Lansing 12
Greenway, Wm. E.....4378 W. Delhi St., Holt
Grey, Anna B.....219 Oakland Dr., East Lansing
Hames, R. E.....205 Medical Arts Bldg., Lansing 12
Hanna, Roger J.....2698 Heather Dr., East Lansing
Harrington, Louis E.....3526 W. Saginaw St., Lansing 17
Harris, Herbert W. 609 N. Washington Ave., Lansing 15
Harrison, Wm. H.....834 W. St. Joseph St., Lansing 15
Harrold, Jesse F.....326 W. Ionia, Lansing 33
Hatton, R. L.....4462 Greenwood St., Okemos
Hayes, Robert E.....204 Medical Arts Bldg., Lansing 12
Hayford, Wm. D.....1028 E. Saginaw St., Lansing
Heald, Gordon H.....714 Abbott Road, East Lansing
Heckert, Frank B. 1105 Bnk. of Lnsg. Bldg., Lansing 16
Heckert, Jos. K.....1105 Bnk. of Lnsg. Bldg., Lansing 16
Heerdt, Mark E.....810 W. Saginaw, Lansing
Henderson, Norman D.....1017 E. Grand River, East Lansing
Henry, Robt. A. (A).....Ypsilanti State Hosp., Ypsilanti
Hermes, Edgar J.....604 W. Willow St., Lansing
Heustis, Albert E.....Mich. Dept. Health, Lansing
Himmelberger, R. J.....3624 Colchester, Lansing 6
Hiscoe, D. Bonta.....2909 E. Grand River, Lansing
Hoffer, W. E. (L).....331 Shepard Street, Lansing
Hogg, Raymond E.....2909 E. Grand River, Lansing
Holland, Chas. F.....810 W. Saginaw, Lansing
Horvath, Francis.....MSU Health Center, E. Lansing
Hoyt, John C.....2107 Aurelius Rd., Holt
Huggett, Clare C.....122 W Gd. River Ave., Lansing
Hurth, M. S.....1717 Jerome St., Lansing
Imeson, Elizabeth W.....Mich. Dept. of Health, Lansing
Isbister, J. L.....Dept. Health DeWitt Rd., Lansing
Iung, Omero S.....411 Bartlett, Lansing
Jacob. S. Sprigg, III.....201 Ann St., East Lansing
Jarstfer, Bruce S. (A).....931 DeCroff, Grand Ledge
Johnson, David B.....2909 E. Grand River, Lansing
Johnson, Henry, T. (N)....P.O. Box 2289, Phoenix, Ariz.
Johnson, Kenneth H.....1116 Mich. Nat. Tower, Lansing
Johnson, Reed P. (N).....139 S. 18 Ave., Maywood, Ill.
Johnson, Richard.....2909 E. Grand River, Lansing
Jones, Francis A., Jr. (R).....815 Royal Palm Pl., Vero Beach, Fla.
Jones, Martin F.....2909 E. Grand River, Lansing
June, Robt. C.....209 N. Walnut, Lansing 33
Kahn, David.....2909 E. Grand River, Lansing
Kalmbach, Roland E.....301 Seymour Ave., Lansing 15
Katlein, Stanley
Kellerman, Howard H.....306 Medical Arts Bldg., Lansing 12
Kelly, William.....Cass Bldg., Lansing
Kent, A. Edith Hall.....Box 1167, Lansing
Kent, Herbert K.....M.O. Box 1167, Lansing 13
Kenyon, Fanny H.....624 LaSalle Blvd., Lansing 12
Kinzel, Raymond C.....326 W. Ionia St., Lansing
Klunzinger, W. R.....326 W. Ionia St., Lansing 33
Kozak, Jerome S.....609 N. Washington Ave., Lansing
Kraft, Lester C.....209 S. Main St., Leslie
Lambert, Harold J.....Mich. Dept. of Health, Lansing
Lange, Philip F.....1923 S. Cedar St., Lansing 10
Lanting, Helen E. P.....600 Lesher Place, Lansing 15
Larkey, Paul E.....110 N. Rosemary St., Lansing
Larson, Homer I.....112 Medical Arts Bldg., Lansing 12
Lauzun, Virginia D...204 Medical Arts Bldg., Lansing 12
LeDuc, Don M.....317 W. St. Joseph St., Lansing
Leshock, Jos. C.....2909 E. Grand River, Lansing
Levett, Harry L.....2909 E. Grand River Ave., Lansing
Lewis, Clayton Jr.....2909 E. Grand River, Lansing
Linnell, Paul C. (A).....1724 Covington, Ann Arbor
Long, Chas. O., Jr.....2909 E. Grand River, Lansing
Lopez, Jose (A).....St. Lawrence Hosp., Lansing
Loree, Maurice C.....120 W. Hillsdale St., Lansing 15
Loughrin, T. D.....335 Seymour, Lansing
Love, James M.....P.O. Box F, Okemos
Lucas, Thos. A.....426 W. Ottawa St., Lansing 15
Ludlum, Lewis C.....1126 W. Saginaw St., Lansing 15
Malcolm, Henry E.....919 E. Grand River, East Lansing
Mannausa, L. R.....919 E. Grand River Ave., E. Lansing
Martin, Wayne O.....4765 Nakoma Dr., Okemos
May, Stephen G.....202 M.A.C. Avenue, E. Lansing
McCorvie, C. Ray.....903 E. Grand River Ave., East Lansing
McCorvie, Donald R.....Williamston Med. Bldg., Williamston
McElmurry, Leland R.....209 N. Walnut St., Lansing 15
McFarlane, Donald R.....101 Medical Arts Bldg., Lansing 12
McGillicuddy, O. B.....1816 Mich. Natl. Tower, Lansing
McGillicuddy, R. J.....300 W. Ottawa St., Lansing 15
Meade, Wm. H.....1023 E. Michigan, Lansing
Meinke, Richard K.....305 Medical Arts Bldg., Lansing 12
Melick, Richard C.....326 W. Ionia, Lansing 33
Mercer, Walter E.....909 Glenhaven, East Lansing
Messenger, A. L.....216 Medical Arts Bldg., Lansing 12

Miller, J. Thomas.....790 E. Columbia, Mason
Miller, Willard J.....930 N. Washington, Lansing
Monfort, Robt. N. (R).....300 Fernwood Rd., Key Biscayne, Miami, Fla.
Moore, Charles R.....112 Medical Arts Bldg., Lansing 12
Moore, Donald B.....312 Medical Arts Bldg., Lansing 12
Morrow, Robt. J.....412 N. Capitol, Lansing
Nadeau, John H. (M) 24679 Rosalind St., East Detroit
Nakfoor, Eugene C.....2909 E. Grand River, Lansing
Neering, James C.....101 Medical Arts Bldg., Lansing 12
Neuman, John R.....3526 W. Saginaw, Lansing
Newitt, A. W.....221 W. Washtenaw, Lansing
Nicholas, Mildred V.....5596 Portage Lake Rd., Dexter
Niland, Paul T.....101 Medical Arts Bldg., Lansing 12
Nobel, Rudolf E. (A).....1577 Andrea, Ypsilanti
Ochsner, Paul J.....Fisher Body Corp., Lansing 4
Packer, John H.....2909 E. Grand River, Lansing
Paine, Wm. G.....1028 E. Saginaw, Lansing
Palmer, R. E. (L).....535 S. Capital Ave., Lansing
Parker, Earl E.....207 E. Bellevue, Leslie
Payne, Thomas C.....2909 E. Grand River Ave., Lansing
Peets, Ronald.....Gr. River & Grandview, Okemos
Perlman, Jack M. (A) 1000 W. Jefferson St., Joliet, Ill.
Philips, David P.....1217 Loraine Ave., Lansing 10
Plant, John F.....2909 E. Grand River, Lansing
Plesscher, Wm. H.....716 Mich. Natl. Tower, Lansing
Pomeroy, Richard W.....102 Medical Arts Bldg., Lansing 12
Prall, Harry J.....214 W. Main St., Lansing 33
Pung, Elba Molina.....1512 E. Michigan, Lansing 12
Randall, O. M. (R).....7557 W. Saginaw R.R. 1, Lansing
Rao, D. S. (A).....MacLaren General Hospital, Flint
Rector, Frank L. (R).....2835 N.E. Brazee Court, Portland 12, Ore.
Reid, Harold E.....359 University Dr., E. Lansing
Reynolds, Edward E.....Rt. 2, Box 1B, Williamston
Richards, Frank D.....1028 E. Saginaw St., Lansing
Richardson, Maurice L.....1215 E. Michigan Ave., Lansing 12
Robson, Edmund J.....215 N. Walnut St., Lansing 15
Rollstin, Robt. A.....1014 Townsend St., Lansing 21
Rozan, Josef S.....2909 E. Grand River, Lansing
Ruhmkorff, Ralph H. MSU Health Center, East Lansing
Rutledge, S. H., Jr...212 Medical Arts Bldg., Lansing 12
Saenz, Hugo R.....1515 W. Mt. Hope, Lansing
Saker, James.....201 W. Hillsdale St., Lansing
Sander, John F.....4780 Okemos Rd., Okemos
Saunders, M. R. (A)
Scallin, J. F.....810 W. Saginaw, Lansing
Schaffer, Carole S. (A) St. Lawrence Hospital, Lansing
Scheidt, R. Rudolph.....1133 Seymour Ave., Lansing
Schmidt, Harry J.....2909 E. Grand River, Lansing
Schultz, Arthur E.....4646 Ottowa Dr., Okemos
Seger, Fred L. (L).....1035 Cherry St. N.E., St. Petersburg 4, Fla.
Shapiro, Hyman D.....201 W. Hillsdale St., Lansing
Sharp, Mahlon S.....521 N. Capitol, Lansing
Shaw, Milton.....320 Townsend St., Lansing 15
Sheehan, F. Michael.....233 Leland Place, Lansing 17
Sheets, Joseph L.....521 N. Capitol Ave., Lansing
Sherman, Geo. A.....112 W. Hillsdale, Lansing 15
Sichler, Harper G. (R).....301 Seymour Ave., Lansing 15
Siegel, David.....2909 E. Grand River, Lansing
Silverman, Irving E.....2909 E. Grand River, Lansing
Sinclair, William J. (A).....308 Michigan Ave., East Lansing
Sleight, Justin L.....2909 E. Grand River, Lansing
Smith, Anthony V.....116 W. Sycamore, Mason
Smookler, Bernard H.....2909 E. Grand River, Lansing
Snyder, LeMoyne.....P.O. Box 1125, Paradise, Calif.
Snyder, Ruth C. E. 234 W. Michigan Ave., East Lansing
Spagnuolo, Alfred J.....1418 S. Logan St., Lansing
Spencer, J. Clyde.....922 Darlington, East Lansing
Spencer, Perry C.....320 Townsend St., Lansing 15
Stanley, Arthur L.....401 W. Greenlawn, Lansing
Stehman, Vernon A.....Lewis Cass Bldg., Lansing
Steiner, Abraham A. (R).....Route 3, Grand Ledge
Stephan, W. E.....302 Medical Arts Bldg., Lansing 12
Stilwill, Geo. D.....2909 E. Grand River, Lansing
Stimson, Paul R.....119 E. Grand River, East Lansing
Stone, Benj. J.....2909 E. Grand River, Lansing
Stow, Robt. M.....2909 E. Grand River, Lansing
Strauss, Percival C.....3813 W. Willow, Lansing
Stringer, C. J.....203 Medical Arts Bldg., Lansing 12
Sundell, Edwin C.....1028 E. Saginaw, Lansing
Swartz, Fredk. C.....720 Seymour St., Lansing
Tamblyn, Fredk. W.....335 Seymour Ave., Lansing 33
Thaden, D. W.....208 M.A.C. Avenue, East Lansing
Thimmig, Robert F...103 Medical Arts Bldg., Lansing 12
Tien, Hsin Chen 124 W. Grand River Ave., East Lansing
Toothaker, Kenneth W.....930 N. Washington Ave., Lansing
Trager, Frederick C...102 Medical Arts Bldg., Lansing 12
Trescott, Robt. F.....716 Mich. Natl. Tower, Lansing
Trimby, Robert H.....215 Medical Arts Bldg., Lansing 12
Troost, Franklin L.....4378 W. Delhi Rd., Holt
Urban, Eva.....540 Glenmoor, East Lansing
Vanderzalm, T. P.....1452 Cambridge Rd., Lansing
Venier, Jos. H.....544 Division, E. Lansing
Wadley, Ralph.....335 Seymour Ave., Lansing 33
Wainright, James W.....720 Seymour Street, Lansing
Walker, Leo W.....4225 Apple Tree Lane, Lansing
Warren, Leon H.....3500 N. Logan St., Lansing
Wellman, John M.....206 Medical Arts Bldg., Lansing 12
West, Chas. Carl.....2909 E. Grand River, Lansing
Wilcox, K. R., Jr.....Mich. Dept. of Health, Lansing
Wilensky, Thos.....201 W. Hillsdale, Lansing
Willson, Howard S.....704 Mich. Nat. Tower, Lansing 8
Worthington, Ralph.....810 W. Saginaw, Lansing 15
Wortley, Chas. K.....1017 E. Grand River, E. Lansing
Zick, Gerald A.....117 Medical Arts Bldg., Lansing 12

IONIA-MONTCALM COUNTY MEDICAL SOCIETY (94)

Anderson, D. Hess.....207 Bridge St., Portland
Bennett, W. Bruce.....Lakeview Hospital, Lakeview
Bird, Wm. L.....110 W. Cass St., Greenville
Birzgalis, Alfreds A.....Ionia State Hosp., Ionia
Buck, Jack H.....517 Division, Ionia
Bunce, Leo W.....Trufant
Campbell, Richard E.....106 N. Depot, Ionia
Dunkin, Lloyd S.....410 S. Clay St., Greenville
Foust, Jos. C. (A).....Kisa Box 73, Tukuyu, Tanganyika, E. Africa
Fox, Harold M. Portland
Geib, Oscar P. (L).....Gaylord
Glerum, John B.....917 W. Oak St., Greenville
Halick, John.....200 S. Franklin, Greenville
Hansen, Carl M. Stanton
Haskell, Robt. H. (L).....Zetlands Estate Twr., Nevis Leeward Isl., BWI
Hoffs, Marinus A.....911 Fourth St., Lake Odessa
House, Glenn W., Jr.....1200 W. Oak St., Greenville
Kazmers, Nikolas Lakeview
Kopchick, Jos. Muir
Kozachik, Martin J.....123 Bridge St., Portland
Kwast, Harold A. (M)
Leider, Thos. R.....230½ W. Main St., Ionia
Lilly, Isaac S., (L).....Stanton
London, John L.....Lakeview
Marston, Leo L.....Box 235, Lakeview
Merchun, Frank A.....11804 W. Carson City Rd., Greenville
Mitchell, Harold C.....509 Johnson St., Ionia

Naglins, Jekabs.....Ionia State Hosp., Ionia
Olsen, Bruce C.....110 W. Cass St., Greenville
O'Malley, R. J.....230½ W. Main, Ionia
Pates, Don C.....Belding
Rice, Robt. E.....P.O. Box 271, Greenville
Robertson, Perry C. (L).....327 Center St., Ionia
Sanford, Louis E.....Wortley Building, Belding
Slagh, Milton E.....Saranac
Smith, Robt. O.....724 Roselawn, Ionia
Socha, Edmund S.....217 E. Main, Ionia
Stevens, Charles E.....513 N. Lafayette St., Greenville
Tannheimer, John F.....525 Lafayette St., Ionia
Van Loo, Jacob.....103 E. Washington St., Belding

JACKSON COUNTY MEDICAL SOCIETY (98)

Adams, Ellis W.....517 Wildwood Ave., Jackson
Ahronheim, J. H.....Foote Memorial Hosp., Jackson
Appel, Saul.....112 W. Michigan Ave., Jackson

Baker, Geo. M.....350 S. Union, Parma
Beckwith, Sidney A.....100 E. Main St., Stockbridge
Bentley, Jack P.....2532 Spring Arbor Rd., Jackson
Bentley, Mary E. N.....2532 Spring Arbor Rd., Jackson
Brashares, Zane A.....Brooklyn
Bullen, G. R.....418 Third St., Jackson
Buslepp, Robert C.....901 Reynolds Bldg., Jackson

Clarke, Corwin S. (L).....1046 Fourth St., Jackson
Cooley, Chas. W.....Mercy Hosp., Jackson
Cooley, Randall M. (L).....141 E. Robinson St., Jackson
Corley, Cecil (L).....204 Homecrest Rd., Jackson
Corley, Ennis H.....1401 Reynolds Bldg., Jackson
Corley, Robt W.....204 Homecrest Rd., Jackson
Cox, Ferdinand (L).....1601 4th St., Jackson

Daly, Byrne M.....297 W. Michigan, Jackson
Davenport, Bruce.....404 McNeal St., Jackson
De May, Cuthbert E.....403 E. Michigan Ave., Jackson
De May, John D.....403 E. Michigan Ave., Jackson
Deming, Richard C.....724 W. Franklin, Jackson
Dengler, Chas. R. (L).....504 3rd St., Jackson
Douglas, Edward W. (L).....468 4th Ave., New Kensington, Pa.

Filip, Hypolit K., Jr.....P.O. Box 84, Jackson
Finton, Robt. E.....610 W. Michigan, Jackson

Greenbaum, Harry.....1203 Greenwood Ave., Jackson
Growt, Bowers H. (L).....Addison

Habenicht, Hilda A.....545 Lansing Ave., Jackson
Hackett, Thos. L.....519 N. East Ave., Jackson
Hamilton, James G.....610 N. West Ave., Jackson
Hanft, Cyril F.....144 E. Main St., Springport
Hardie, Geo. C.....724 W. Michigan, Jackson
Hicks, Glenn C. (L).....1009 Wildwood Ave., Jackson
Holst, John B.....606 City Bank Bldg., Jackson

Joerin, Wm. A.....612 First St., Jackson

Karr, Jean P.....502 W. Michigan Ave., Jackson
Keefer, Albert H.....Concord
Kempton, Geo. B.....511 S. West Ave., Jackson
Kiessling, A. J., Jr.....511 S. West Ave., Jackson
Kline, Starr L. (L).....3525 Jefferson Rd., Clark Lake
Kobs, Robt. J.....608 W. Michigan Ave., Jackson
Kudner, Donald F.....435 Wildwood Ave., Jackson

Lake, Edward C.....612 1st St., Jackson
Landron, Danl.....4633 Page, Michigan Center
Lenz, Chas. R., Jr.....405 1st St., Jackson
Lewis, Elmore F. (L).....1112 Carlton Blvd., Jackson
Linden, Victor E.....2025 Fourth St., Jackson
Llinas, Jose J.....1215 First St., Jackson
Ludwick, John E.....237 W. Washington Ave., Jackson
Ludwick, John P.....237 W. Washington Ave., Jackson

Maas, Gerald I.....1615 Carlton Blvd., Jackson
McGarvey, Wm. E. (L)..161 W. Michigan Ave., Jackson
McLaughlin, John M.....710 S. Brown St., Jackson
McLaughlin, Miar J. (L).....710 S. Brown St., Jackson
McLauthlin, H. B.....439 Wildwood Ave., Jackson
McQuillan, F. P.....611 Center St., Jackson
Meads, Jason B.....161 W. Michigan Ave., Jackson
Medlar, Robt E.....719 Seventeenth St., Jackson
Morelli, Lorenzo.....401 W. Prospect St., Jackson
Muhich, Ralph A.....2532 Spring Arbor Rd., Jackson
Munro, Colin D. (L).....740 W. Michigan, Jackson
Munro, Nathan D.....740 W. Michigan, Jackson
Murphy, Bernard M.....1134 E. Ganson St., Jackson

Newton, Ray E.....180 W. Michigan Ave., Jackson
Niekamp, Harold.....2532 Spring Arbor Rd., Jackson

Oleksy, Stanley P.....744 W. Michigan, Jackson
Olsen, Lloyd L.....610 W. Michigan Ave., Jackson
Oster, Harold L.....1218 Greenwood Ave., Jackson
Otis, Grant L.....525 Wildwood Ave., Jackson

Payne, Andrew K.....Foote Memorial Hosp., Jackson
Phillips, Geo. H.....Jackson Co. T.B. Sanat., Jackson
Porter, Horace W. (L).....505 Wildwood Ave., Jackson
Pray, Frank F. (L).....310 Steward Ave., Jackson
Pray, Geo. R. (L).....404 S. Jackson St., Jackson
Preston, Joseph A.....Mercy Hospital, Jackson

Rice, John W.....421 McNeal St., Jackson
Ries, Richard G.....612 First St., Jackson
Riley, Philip A.....500 S. Jackson St., Jackson
Riley, Philip A., Jr.....500 S. Jackson St., Jackson
Rua, Ignacio.....1810 W. High, Jackson
Rucker, Joseph.....1012 Francis St., Jackson

Sargent, Leland E.....Foote Memorial Hosp., Jackson
Sautter, Wm. A.....Horton
Schneider, R. H.....724 W. Franklin, Jackson
Scott, John A., Jr.....432 W. Michigan, Jackson
Shaeffer, Leland D.....1615 Carlton Blvd., Jackson
Sher, David B. (R).....3800 Kirkwood, Jackson
Sill, Henry W.....724 W. Michigan Ave., Jackson
Sirhal, Alfred M.....Brooklyn
Smith, Dean W.....500 W. Michigan Ave., Jackson
Southwick, W. A.....130 Maple St., Springport
Stackable, Wm. R.....2532 Spring Arbor Rd., Jackson
Stewart, Lewis L., Jr.....1919 Kibby Rd., Jackson
Stolberg, Carl A.....724 W. Franklin, Jackson
Stone, Ethon L.....721 Seventeenth St., Jackson
Sugar, Saml.....180 W. Michigan Ave., Jackson

Tate, Cecil E.....1315 Francis St., Jackson
Taylor, Ross V.....517 Wildwood Ave., Jackson
Thalner, Leonard F.....609 W. Michigan Ave., Jackson
Thayer, Earl A. (L).....120 W. Michigan Ave., Jackson
Thompson, T. B.....434 Wildwood Ave., Jackson
Townsend, James W.....108 Hague Ave., Vandercook Lake, Jackson

Van Schoick, Frank.....419 W. High St., Jackson
Van Schoick, John D.....Hanover
Van Wagnen, F. I., Jr.....434 Wildwood Ave., Jackson
Vivirski, Edward E.....603 S. Elm Ave., Jackson

Weddon, Edward R.....R.F.D. 2, Stockbridge
Wholihan, John W.....604 W. Michigan Ave., Jackson
Wickham, Woodward A.....2029 Fourth, Jackson
Wille, Warren S.....1204 First St., Jackson

KALAMAZOO ACADEMY OF MEDICINE (102)

Aach, Hugo A.....3314 Bronson Blvd., Kalamazoo 37
Ajemian, Edward P.....252 E. Lovell St., Kalamazoo
Alexander, C. A.....118 W. North St., Kalamazoo
Andrews, Sherman E.....224 E. Cedar St., Kalamazoo 8
Andrews, Thomas E.....224 E. Cedar St., Kalamazoo
Angell, Howard H. (A)....301 Henrietta St., Kalamazoo
Anglin, Walter M.....7211 Lantollarrey Rd., Kalamazoo
Appel, Ben A.....252 E. Lovell St., Kalamazoo
Appel, Wm. P.....252 E. Lovell St., Kalamazoo 8
Appell, Lloyd E.....126 N. Kalamazoo Ave., Vicksburg
Armstrong, Robt J.....103 N. Burdick St., Kalamazoo 1

Balian, John V.....501 Bronson Med. Cen., Kalamazoo
Banner, Lawrence R.....Borgess Med. Cen., Kalamazoo
Barrows, Winona M.....1500 Blakslee St., Kalamazoo
Barry, Manley L.....Plainwell Sanit., Plainwell
Bateman, William T.....914 S. Burdick, Kalamazoo
Bennett, Keith F.....252 E. Lovell St., Kalamazoo
Berglund, Thomas R.....6646 Portage Rd., Kalamazoo
Berglund, V. A.....6646 Portage Rd., Kalamazoo
Berry, Ivor, Jr.....516 Whites Rd., Kalamazoo
Betz, Eldean G.....1711 Merrill, Kalamazoo 6
Birch, Wm. G.....252 E. Lovell St., Kalamazoo 5
Bodmer, Harvey C...403 W. Kalamazoo Ave., Kalamazoo
Bond, Glenn C. (A).....2824 S. Burdick St., Kalamazoo
Breneman, James C.....25 Pearl St., Galesburg
Brooks, Bert W.....4340 Lakeside Dr., Kalamazoo
Brown, Irmel W.....107 W. Michigan Ave., Kalamazoo
Brue, Peter P.....1009 Cambridge Dr., Kalamazoo
Burrell, Robt B.....1711 Merrill St., Kalamazoo
Butler, Wm. J.....1631 Gull Rd., Kalamazoo

Callander, C. Glen.....252 E. Lovell St., Kalamazoo
Carter, E. R.....1324 S. Park St., Kalamazoo
Cartland, Geo. F., Ph.D. (A).....1704 Dover Rd., Kalamazoo
Cashen, Russell M.....252 E. Lovell St., Kalamazoo
Chrest, Clarence P.....458 W. South St., Kalamazoo
Clement, F. L.....502 Bronson Med. Cen., Kalamazoo
Conrad, Maynard M.....252 E. Lovell St., Kalamazoo
Cooper, Paul F.....252 E. Lovell St., Kalamazoo
Cornish, F. L., III.....1631 Gull Rd., Kalamazoo
Cox, Franklin.....Borgess Hospital, Kalamazoo
Crawford, Kenneth L.....612 Douglas, Kalamazoo
Crawley, Kenneth R. (A)..301 Henrietta St., Kalamazoo
Creager, Ray O.....1218 Bronson Circle, Kalamazoo
Cretsinger, Francis C.....224 E. Cedar St., Kalamazoo
Currier, Richard K.....6646 Portage Rd., Kalamazoo

Dahlstrom, Doris E.....723 S. Westnedge Ave., Kalamazoo
Damiano, Robert E.....301 Henrietta St., Kalamazoo
Dana, Robt. L.....228 W. Cedar St., Kalamazoo
Decker, Wm. A.....1207 Oakland, Kalamazoo
Delbert, Stewart G.....914 S. Burdick St., Kalamazoo
DeLong, Robt. E.....Borgess Med. Center, Kalamazoo
DePree, Harold E.....252 E. Lovell St., Kalamazoo
DeVries, John M.....516 Whites Rd., Kalamazoo
Dew, Robt. R.....1711 Merrill St., Kalamazoo
DeWitt, Norman L.....103 N. Burdick St., Kalamazoo
Dick, Leo A.....611 Howard St., Kalamazoo
Doezema, Edward R.....516 Whites Rd., Kalamazoo
Dowd, Bennard J.....1700 Gull Road, Kalamazoo
Doyle, Fredk. M.....611 Howard St., Kalamazoo
Dugger, James A.....2901 S. Westnedge Ave., Kalamazoo

Endrei, Arisztid.....1312 Oakland Dr., Kalamazoo
Estill, Don V.....414 W. Patterson St., Kalamazoo

Fath, August F.....1711 Merrill, Kalamazoo
Ferguson, Robt. K.....1324 S. Park, Kalamazoo
Finton, Max A.....252 E. Lovell St., Kalamazoo
Flunt, Roman.....Box A. Kalamazoo St. Hosp., Kalamazoo
Fopeano, John V.....1711 Merrill St., Kalamazoo
Fry, J. William.....420 John St., Kalamazoo
Fuller, Paul M.....1700 Gull Road, Kalamazoo
Furlong, N. Kenneth.....St. Francis Hosp., Peoria, Ill.

Gardner, Carl A.....1410 Amer. Natl. Bank, Kalamazoo
Gerard, Earl S. (A)....3410 Runnymede Dr., Kalamazoo
Gerstner, Louis W.....420 John St., Kalamazoo
Gerstner, Richard M.....212 Bronson Med. Center, Kalamazoo
Gibson, Richard E.....Schoolcraft
Ginnebaugh, L. A.....77 Rose St., Battle Creek
Gladstone, Wm. S.....458 W. South St., Kalamazoo
Glaser, Danl. F.....463 Academy St., Kalamazoo
Goodhue, Lolita G.....2503 W. Main St., Kalamazoo
Gove, Robert S.....1631 Gull Rd., Kalamazoo
Graf, Michael.....1631 Gull Rd., Kalamazoo
Grekin, Robt. H.....136 E. Michigan Ave., Kalamazoo
Gremel, Norman.....458 W. South St., Kalamazoo

Haddock, D. A., Jr.....6646 Portage St., Kalamazoo
Hagans, James A.....301 Henrietta St., Kalamazoo
Hailman, Harold F.....301 Henrietta St., Kalamazoo
Hammer, John M.....100 Maple St., Parchment
Hanson, Curtis M.....252 E. Lovell St., Kalamazoo
Hare, J. Donald.....516 Whites Rd., Kalamazoo
Harrell, Frank G.....1602 Gull Rd., Kalamazoo
Harrelson, Wm. D.....1324 S. Park, Kalamazoo
Harvey, Donald A. (A)....2222 Fuller Road, Ann Arbor
Hayner, Russell A.....4015 Portage, Kalamazoo
Heersma, H. Sidney.....1711 Merrill St., Kalamazoo
Heinle, Robt. W.....Med. Div. Upjohn Co., Kalamazoo
Hendrix, J. W. (A).....2430 Wildemere St., Kalamazoo
Hersey, E. Freeman.....1215 Oakland Dr., Kalamazoo
Hersey, Margaret S.....1215 Oakland Dr., Kalamazoo
Hildreth, Roscoe C.....458 W. South St., Kalamazoo 46
Hodgman, Albert B.....612 Douglas Ave., Kalamazoo
Hoebeke, Wm. G. (L).....1408 Long Rd., Kalamazoo
Hoekstra, George J.....100 Maple St., Parchment
Howard, R. Grant.....1697 Ala Moana Blvd., Honolulu, Hawaii
Howard, Willard H.....1536 Gull Rd., Kalamazoo
Hubbard, Edwin M.....252 E. Lovell St., Kalamazoo
Hume, Robt H.....1711 Merrill St., Kalamazoo
Hunt, Jack.....1631 Gull Rd., Kalamazoo
Huyser, Wm. C. (L).....427 S. Burdick St., Kalamazoo

Irwin, Wm. D.....103 N. Burdick St., Kalamazoo

Janke, Robert A.....1416 W. Milham Rd., Kalamazoo
Jennings, Robt. M.....Box A, Kalamazoo State Hosp., Kalamazoo
Johnson, Fenimore T. (A).....Med. Div., Upjohn Co., Kalamazoo

Kavanaugh, John.....1631 Gull Rd., Kalamazoo
Kavanaugh, Wm. R.....612 Douglas Ave., Kalamazoo
Kercher, Ervin F.....2019 Ramblin, Kalamazoo
Kihm, John L.....1223 S. Park St., Kalamazoo
Kilgore, Robt. N.....252 E. Lovell St., Kalamazoo
Kincaid, Joseph E.....420 John St., Kalamazoo
Klerk, Wm. J.....914 S. Burdick St., Kalamazoo
Koestner, Paul A.....1303 Portage St., Kalamazoo

Lavender, Howard C. (A).....136 E. Michigan Ave., Kalamazoo
Lawrence, James O.....1409 Henderson Dr., Kalamazoo
Lawson, James B. (A).....Rt. 1, Box 190, Vicksburg
Lemmer, Richard A.....252 E. Lovell St., Kalamazoo
Light, Richard U.....916 Amer. Nat. Bldg., Kalamazoo
Littig, John D.....1324 S. Park St., Kalamazoo
Locklin, W. Kaye.....136 E. Michigan, Kalamazoo
Louisell, James M.....611 Whitcomb St., Kalamazoo
Lowe, W. Carter.....252 E. Lovell St., Kalamazoo
Loynd, James W., II.....1324 S. Park St., Kalamazoo

MacDonald, M. A.....252 E. Lovell St., Kalamazoo
MacGregor, John R.....100 Maple St., Parchment
Machin, Harold A.....420 John St., Kalamazoo
Malone, James G.....420 John St., Kalamazoo
Margolis, Fredk. J.....2901 S. Westnedge, Kalamazoo
Marshall, Don.....252 E. Lovell St., Kalamazoo
Marshall, Evelyn M. W. (A).....1508 Timberlane Dr., Kalamazoo
Marshall, Wm. P.....705 Hanselman Bldg., Kalamazoo
Martens, Irvin J.....1521 Gull Rd., Kalamazoo

Mason, Donald V.....408 W. Milham Rd., Kalamazoo
May, Donald G.....516 Whites Rd., Kalamazoo
McColl, John A.....1631 Gull Rd., Kalamazoo
McLeod, Garrard A., Ph.D. (A).....Upjohn Company, Kalamazoo
McMahon, F. Gilbert....4302 Edgecliff Lane, Kalamazoo
Mellis, Richard.....611 Whitcomb St., Kalamazoo
Moe, Carl R.....1324 S. Park St., Kalamazoo
Molony, Basil A.....3603 Runnymede Dr., Kalamazoo
Morter, Roy A. (L).....2421 Sheffield, Kalamazoo
Murdy, Robert C.....Box A. Kalamazoo St. Hosp., Kalamazoo
Neerken, Adrian J.....404 Bronson Med. Center, Kalamazoo
Nicholson, Robt. M.....1711 Merrill, Kalamazoo
O'Donovan, C. J.....664 Contention Lane, Berwyn, Penna.
Overbey, Chas. B., Jr.....1000 Oakland Dr., Kalamazoo
Patmos, Martin.....252 E. Lovell St., Kalamazoo
Peake, Chas. O., III.....252 E. Lovell St., Kalamazoo
Pearson, Edwin O.....458 W. South St., Kalamazoo 46
Peelen, J. W.....611 Whitcomb St., Kalamazoo
Peelen, Matthew.....252 E. Lovell St., Kalamazoo
Peltier, Hubert C. (A).....The Upjohn Company, Kalamazoo
Perry, Clifton W.....1711 Merrill St., Kalamazoo
Pinkham, Raymond A.....611 Whitcomb St., Kalamazoo
Pool, John D.....1711 Merrill St., Kalamazoo
Powley, Gerald W.....1711 Merrill St., Kalamazoo
Pullon, Alton E.....1223 S. Park St., Kalamazoo
Rasmussen, Leo B.....152 N. Main St., Vicksburg
Reigel, Thomas J., Jr.....2019 Rambling Rd., Kalamazoo
Rice, Franklyn G...Western Michigan Univ., Kalamazoo
Rigterink, Gerald H.....433 S. Rose St., Kalamazoo
Roberts, Millard S.....1631 Gull Rd., Kalamazoo
Rockwell, Donald C.....1718 Amer. Natl. Bk. Bldg., Kalamazoo
Rogers, Rodney J.....126 N. Kalamazoo, Vicksburg
Rutherford, P. S.....Borgess Hospital, Kalamazoo
Ryan, Fredk. C.....1631 Gull Rd., Kalamazoo
Sage, Edward D. (L)..902 Hanselman Bldg., Kalamazoo
Schaefer, Donald S.....1416 W. Milham Rd., Kalamazoo
Scherer, Flora E.....Box A, Kalamazoo State Hosp., Kalamazoo
Scholl, James W.....1631 Gull Rd., Kalamazoo
Scholten, Roger A.....252 E. Lovell St., Kalamazoo
Scholten, William (R)....345 N. Burdick St., Kalamazoo
Schrieber, R. S., Ph.D. (A).....Upjohn Co., Kalamazoo
Schrier, Clarence T. M.....1000 Oakland Dr., Kalamazoo
Schrier, Paul G.....252 E. Lovell St., Kalamazoo
Schrier, Thomas.....Box 88, Comstock
Schut, Almon L.....401 Bronson Med. Cen., Kalamazoo
Schwallie, Paul C. (A)....824 Sunrise Circle, Kalamazoo
Scott, William A.....1631 Gull Rd., Suite 212, Kalamazoo
Simpson, Bernard W.....610 S. Burdick, Kalamazoo
Slatmyer, Karel R., Jr.....705 Hanselman Bldg., Kalamazoo
Slenger, Walworth R.....508 Village, Kalamazoo
Sofen, Morris B.....107 W. Michigan Ave., Kalamazoo
Southworth, M. N.....Schoolcraft
Springgate, R. R.....1631 Gull Rd., Kalamazoo
Stewart, R. B.....705 Hanselman Bldg., Kalamazoo
Stewart, Wm. C., Jr.....2019 Rambling Rd., Kalamazoo
Stiller, Anthony F.....1235 N. Hillandale Dr., Kalamazoo
Stryker, Homer H.....Borgess Med. Center, Kalamazoo
Stubbs, Samuel S. (A).....1342 Lama Rd., Kalamazoo
Swann, Raymond O.....611 Whitcomb St., Kalamazoo
Talanda, Edmund.....3125 W. Main, Kalamazoo
Tucker, Harold A. (A).....Upjohn Co., Kalamazoo
Upjohn, E. Gifford.....301 Henrietta St., Kalamazoo
Upjohn, Harold.....301 Henrietta St., Kalamazoo
Van Arendonk, Gerald.....611 Howard St., Kalamazoo
Vander Velde, K. M.....Bronson Med. Cen., Kalamazoo
Varley, Alan B.....2146 Treehaven Dr., Kalamazoo
Vecchio, Thomas J.....5250 Grosse Pte. St., Kalamazoo
Verhage, Martin D.....228 W. Cedar St., Kalamazoo
Volderauer, John C.....458 W. South St., Kalamazoo
Walker, John S.....301 Henrietta St., Kalamazoo
Warnke, Robt. D.....1631 Gull Rd., Kalamazoo
Weadon, Preston S.....252 E. Lovell St., Kalamazoo
Webb, Joseph P. (A).....301 Henrietta St., Kalamazoo
Wenner, Wm. F. (A).....1715 Dover Rd., Kalamazoo
Wilbur, Edward P. (L)....1730 Dover Rd., Kalamazoo 38
Williamson, Edwin M.....252 E. Lovell St., Kalamazoo
Wilson, Doyle E.....252 E. Lovell St., Kalamazoo
Wu, Jack F.....810 E. Center Ave., Kalamazoo
Yang, William G.....3125 W. Main St., Kalamazoo
Youngs, Cyril A.....416 S. Burdick St., Kalamazoo
Zolen, Margaret H.....628 S. Park St., Kalamazoo
Zwergel, Edward H.....5207 Morningside Dr., Kalamazoo

KENT COUNTY MEDICAL SOCIETY (106)

Adams, Frank A.....526 Leonard St. N.W., Grand Rapids
Aitken, Geo. T.....50 College Ave. S.E., Grand Rapids 3
Albers, G. Donald....203 Paris Ave. S.E., Grand Rapids 3
Albers, Robt.....788 Columbia, Holland
Aldridge, Chas. W., Jr.....153 Lafayette S.E., Grand Rapids 3
Alfenito, Felix S., Jr.....515 Lakeside Dr. S.E., Grand Rapids
Alger, George D...2060 Alpine Ave. N.W., Grand Rapids
Allen, L. Willis.....245 State St. S.E., Grand Rapids 3
Allen, Ralph V.....1669 Plainfield Ave. N.E., Grand Rapids 5
Anderson, Karl A. (A).....2663 Reeds Lake Blvd., Grand Rapids
Andre, Harvey M...500 Cherry St. S.E., Grand Rapids 3
Andrews, E. B. (A)..1421 Lakeland Dr., Knoxville, Tenn.
Avery, Noyes L., Jr.....515 Lakeside Dr. S.E., Grand Rapids
Baker, Abel J. (L)..549 Rosewood S.E., Grand Rapids 6
Baker, Robt. J.....6850 Division Ave. S., Grand Rapids 8
Bakker, Durward J...1033 Fulton St. W., Grand Rapids 4
Ballard, Milner S.....146 Monroe Ave., N.W., Grand Rapids
Balyeat, Gordon W.....150 Morningside Dr., Grand Rapids 6
Barofsky, Gerald F.....808 Alger St. S.E., Grand Rapids 7
Bartek, Gordon L.....110 E. Fulton St., Grand Rapids
Basinger, Clair E...1810 Wealthy St. S.E., Grand Rapids
Baum, Wm. C.....153 Lafayette S.E., Grand Rapids 3
Beaton, James H.....153 Lafayette S.E., Grand Rapids 3
Beeman, Carl B...515 Lakeside Dr. S.E.,Grand Rapids 6
Beets, W. Clarence....124 Fulton St. E., Grand Rapids 2
Bell, Chas. M.....50 College Ave. S.E., Grand Rapids 3
Benisek, George J. (A).....322 Lakewood Dr. S.E., Grand Rapids 6
Benjamin, Howard G.....72 Sheldon Ave. S.E., Grand Rapids 2
Bennett, Wm. D. (A).....1823 Plainfield N.E., Grand Rapids 5
Benson, Roland R.....201 Lafayette S.E., Grand Rapids 3
Bergsma, Stuart.....6850 Division S., Grand Rapids 8
Beukema, Marenus J.....6850 S. Division Ave., Grand Rapids 8
Bignall, C. Rexford....245 State St. S.E., Grand Rapids 3
Birch, Larry H.....100 Michigan St. N.E., Grand Rapids
Blocksma, Ralph.....245 State St. S.E., Grand Rapids 3
Boelkins, Richard C.....125 Fountain St. N.E., Grand Rapids 3
Boerman, Walter J.....2060 Alpine Ave. N.W., Grand Rapids
Boersma, Donald.....920 Chippewa, Grand Rapids
Boet, John T.....750 Fuller Ave. N.E., Grand Rapids
Bond, Geo. L. (L).....Box 303, Rt. 5, Charleston, S. C.

Bonzelaar, Marvin.....2740 Eastern Ave. S.E., Grand Rapids
Booher, Craig E.....1810 Wealthy St. S.E., Grand Rapids 6
Botting, A. J.....2360 84th St. S.W., Byron Center
Bowman, Harold E...201 Lafayette S.E., Grand Rapids 3
Boyce, David C...515 Lakeside Dr. S.E., Grand Rapids 6
Brace, Fredk. C.....1498 Lake Dr. S.E., Grand Rapids 6
Bratt, Harvey J.....833 Lake Dr. S.E., Grand Rapids 6
Braunschneider, Geo. E.....1632 Leonard St. N.W., Grand Rapids 4
Brink, J. Russell....50 College Ave. S.E., Grand Rapids 3
Brotherhood, James S. (L).....3531 Patterson, Grand Rapids
Bull, Frank L.....72 E. Division, Sparta
Bull, R. John (A).....6724 83rd St. W., Overland Park, Kans.
Burhans, Gregory L. (A).....641 Ottillia Ave. S.E., Grand Rapids 7
Burhans, John B.....515 Lakeside Dr. S.E., Grand Rapids
Burica, George J. (A).....1840 Wealthy St. S.E., Grand Rapids 6
Burleson, John S.....531 Greenwood S.E., Grand Rapids 6
Burling, Wesley M. (L).....129 Michigan St. N.E., Grand Rapids 3
Burroughs, F. M., Jr. (A).....3307 Ottawa, Grandville
Burton, Robert D.....515 Lakeside Dr. S.E., Grand Rapids 6
Butler, Wm. J. (A).....8 Paseo Redondo Apt. C, Tucson, Ariz.
Byrd, Mary L...700 Kent Hills Rd. N.E., Grand Rapids 5
Capps, Samuel C...100 Michigan St. N.E., Grand Rapids
Carpenter, L. C.....50 College Ave. S.E., Grand Rapids 3
Cate, James R. (A)....8430 Atherlon Dr., St. Louis, Mo.
Caukin, Howard S...500 Cherry St. S.E., Grand Rapids 3
Cayce, Wm.....245 State St., S.E., Grand Rapids 3
Champion, John P.2222 Englewood S.E.,Grand Rapids 6
Chandler, Donald.....Rt. No. 4, East Belt Line, Grand Rapids 5
Chase, Robert J.....833 Lake Drive S.E., Grand Rapids
Chen, Mey En (A).....518 Belvedere Dr. S.E., Grand Rapids 6
Clahassey, Erwin G.....50 College Ave. S.E., Grand Rapids 3
Clawson, Carroll K.....445 Cherry St. S.E., Grand Rapids
Claytor, Robt. W.....1424 Madison Ave., S.E., Grand Rapids 7
Clodfelder, R. Paul (A).....1312 Northfield N.E., Grand Rapids 5
Corbus, Burton R. (L).....325 Union Ave. S.E., Grand Rapids 6
Crane, Harold D...26 Sheldon Ave. S.E., Grand Rapids 2
Cremer, John A.....911 Leonard St. N.W., Grand Rapids
Crissman, Richard K.....2747 Clyde Park S.W., Grand Rapids
Dales, Ernest W. (L).....146-156 Monroe Ave. N.W., Grand Rapids 2
Dassell, Paul M.....2641 Boston S.E., Grand Rapids 6
Davis, David B.....266 Pettis Ave. N.E., Ada
Davis, Roy A.....4236 Kalamazoo Ave. S.E., Grand Rapids 8
Davis, Thomas B.....1810 Wealthy St. S.E., Grand Rapids 6
Dawson, Walter D.....408 Medical Arts Bldg., Grand Rapids 2
Dean, Alfred (L).....Sagola
DeBoer, Arthur F. (A).....Takum Christian Hosp., Wukari via Makurdi, North Nigeria, West Africa
DeBoer, Clarence J.....3011 Wilson S.W., Grandville
DeBoer, Guy W...26 Sheldon Ave. S.E., Grand Rapids 2
Delnay, Richard M.....124 Fulton St. E., Grand Rapids 2
DeMaagd, Gerald.....143 Courtland, Rockford
DeMol, Richard J.....1414 Eastern Ave. S.E., Grand Rapids 7
DePree, Isla G.....14 Monroe Ave. N.E., Grand Rapids 2
DePree, Joe (L)..1810 Wealthy St. S.E., Grand Rapids 6
DeVel, Leon....739 Plymouth Blvd. S.E., Grand Rapids 6
DeVries, Danl.....1414 Eastern Ave. S.E., Grand Rapids 7
Dewey, Kent A.....456 Cherry St. S.E., Grand Rapids 3
DeYoung, M. T.....1505 Twelve Mile Rd., Sparta
Dice, Nanette.....535 Greenwood Ave. S.E., Grand Rapids 6
Dick, Mark W...146 Monroe Ave. N.W., Grand Rapids 2
Diskey, Donald G.....2015 Bridge N.W., Grand Rapids 4
Dixon, Willis L.....26 Sheldon Ave. S.E., Grand Rapids 2
Docter, Luebert....26 Sheldon Ave. S.E., Grand Rapids 2
Doorenbos, Harvey E.
Doornbos, Fred A.....245 State, S.E., Grand Rapids
Dorain, Wallace B.....1810 Wealthy St. S.E., Grand Rapids 6
Doran, Frank L.....110 Fulton St. E., Grand Rapids 2
Doyle, John L...2402 Eastern Ave. S.E., Grand Rapids 7
Dye, Robert A.....124 E. Fulton, Grand Rapids
Eary, L. Edmond, Jr.....52 Orchard Dr., Sparta
Eaton, Robt. M. (A).....Christian Hospital, Meshed, Iran
Edholm, Curtis D.....50 College Ave. S.E., Grand Rapids 3
Eggleston, Robert L. (A).....American Embassy, Kula, Lumpur, Federation of Malaya
Eldersveld, Herman C.....815 Alger St. S.E., Grand Rapids
Ellis, Michael E.....242 Jefferson S.E., Grand Rapids
Ericsson, Kermit C. (A).....1045 Keneberry Way S.E., Grand Rapids 6
Failing, John F...2617 Lake Mich. N.W., Grand Rapids 4
Falbisaner, G. J.....3000 Monroe Ave. N.W., Grand Rapids
Farber, Chas. E.....50 College Ave. S.E., Grand Rapids 3
Fatum, Paul J.....124 Fulton St. E., Grand Rapids 2
Faust, Lawrence W.....Morrison Lake Gardens, Saranac
Feenstra, L. H.....833 Lake Dr. S.E., Grand Rapids 6
Fellows, Kenneth E...515 Lakeside S.E., Grand Rapids 6
Ferguson, James A.....2230 Hall St. S.E., Grand Rapids 6
Ferguson, Lynn A.....72 Sheldon Ave. S.E., Grand Rapids 2
Ferrand, Louis G.....8149 Northland Dr., Rockford
Finnie, Gordon M. (A).....118 E. Walnut, Hastings
Fitts, Ralph L.....50 College Ave. S.E., Grand Rapids 3
Fitzgerald, Erwin L.....50 College Ave. S.E., Grand Rapids 3
Flintoff, Wm. M.....1660 Diamond Ave. N.E., Grand Rapids 5
Flynn, J. Donald....515 Lakeside Dr. S.E., Grand Rapids
Fochtman, Thos. W.....72 E. Division, Sparta
Foshee, J. Clinton.....124 Fulton St. E., Grand Rapids 2
Foxworthy, John P.....50 College Ave. S.E., Grand Rapids 3
Frantz, Charles H...1810 Wealthy St. S.E., Grand Rapids
Fuller, Edson H., Jr.....74 Ionia Ave. N.W., Grand Rapids 2
Fuller, Raymond E.....515 Lakeside Dr. S.E., Grand Rapids 6
Fuller, Wm. J.....515 Lakeside Dr. S.E., Grand Rapids 6
Gamm, Kenneth E...153 Lafayette S.E., Grand Rapids 3
Gerard, Donald G.....311 E. Main St., Lowell
Gibbs, Floyd F.....4338 Division Ave. S., Grand Rapids 8
Gilbert, Ralph H.....26 Sheldon Ave. S.E., Grand Rapids
Gillett, Fredk. S.....50 College Ave. S.E., Grand Rapids
Glessner, James R., Jr.....1810 Wealthy St. S.E., Grand Rapids 6
Goldberg, Salomea J.....515 Lakeside Dr. S.E., Grand Rapids 6
Golden, Michael F. (A).....411 Sunset Dr., Downington, Pa.
Good, C. Robert....2745 DeHoop St. S.W., Grand Rapids
Graff, Russell G.....25 E. Dayton St., Fremont
Grass, Edward J.....833 Lake Dr. S.E., Grand Rapids 6
Gray, Fred B.....456 Cherry St. S.E., Grand Rapids 3
Greene, Perry W., Jr.....26 Sheldon Ave. S.E., Grand Rapids 2
Griffith, Lucian S.....50 College Ave. S.E., Grand Rapids 3
Grosenbaugh, Clare H.....515 Lakeside Dr. S.E., Grand Rapids

Gunn, James A...1840 Wealthy St. S.E., Grand Rapids 6
Gunning, Robt. E. Lee.....369 Greenwich Rd. N.E., Grand Rapids
Haarer, John G.....733 Alger S.E., Grand Rapids
Haeck, William.....245 State St. S.E., Grand Rapids 3
Hagerman, David B. (L).....1085 Leonard St. N.E., Grand Rapids 5
Hamp, Arthur K.....515 Lakeside Dr. S.E., Grand Rapids 6
Harrison, Robert W.....1810 Wealthy St. S.E., Grand Rapids 6
Hayes, L. W., Sr. (R).....Howard City
Hayes, Robert E.....456 Cherry St. S.E., Grand Rapids 3
Hayes, Thomas A.....1940 Griggs St. S.E., Grand Rapids 6
Heaton, John R.....72 Sheldon Ave. S.E., Grand Rapids
Heetderks, Dewey R...245 State St. S.E., Grand Rapids 2
Helder, Louis.....833 Lake Dr. S.E., Grand Rapids
Helmus, Christian....203 Paris Ave. S.E., Grand Rapids 3
Herrick, Ruth.....908 E. Main St., Lowell
Hesselschwerdt, D. W.....932 Floral Drive S.E., Grand Rapids
Hill, A. Morgan....50 College Ave. S.E., Grand Rapids 3
Hill, Thos. B.....554 Durand, East Lansing
Hoekstra, Andrew L.....26 Sheldon Ave. S.E., Grand Rapids 2
Hoekstra, Philip J.....68 Ransom N.E., Grand Rapids
Hoffs, Albertus J.....2607 Fredericks Dr. S.E., Grand Rapids 6
Holkeboer, Henry D. (A).....1050 Spaulding Ave. S.E., Grand Rapids 6
Hollander, Stephen.....1451 Grandville Ave., Grand Rapids 9
Hoogerhyde, Jack.....26 Sheldon Ave. S.E., Grand Rapids 2
Horning, David J.....26 Sheldon Ave. S.E., Grand Rapids 2
Howard, Leonard R. (A).....Tripler Gen. Army Hosp., APO 438, San Francisco, Calif.
Hoyt, Robt. L.....1810 Wealthy St. S.E., Grand Rapids 6
Hudson, A. Thomas.....72 Sheldon Ave. S.E., Grand Rapids 2
Hudson, Harry C...50 College Ave. S.E., Grand Rapids 3
Hufford, A. Ray.....260 Jefferson Ave. S.E., Grand Rapids 3
Humphrey, James C.....26 Sheldon Ave. S.E., Grand Rapids 2
Hunderman, Edward D. (L).....538 Eastern Ave. S.E., Grand Rapids 6
Hutchinson, F. A.....245 State St. S.E., Grand Rapids
Hydrick, Robt. H..... 1039 W. Fulton, Grand Rapids
Hyland, Wm. A.....515 Lakeside Dr. S.E., Grand Rapids
Ireland, Hoesa D.....750 Fuller Ave. N.E., Grand Rapids
Irwin, James R. (A).....1022 Floral Dr. S.E., Grand Rapids 6
Irwin, Jerry L. (A).....3965 Campbell, Dearborn
Jack, Wm. W.....1810 Wealthy St. S.E., Grand Rapids 6
Jameson, Fred M.....833 Lake Dr. S.E., Grand Rapids 6
Jaracz, Walter J.....634 Bridge St. N.W., Grand Rapids 4
Jaracz, Walter J., Jr.....634 Bridge St. N.W., Grand Rapids 4
Jarka, Robt. W.....50 College Ave. S.E., Grand Rapids 3
Jarvis, Chas., Jr.....1520 Plainfield Ave. N.E., Grand Rapids 5
Jellema, John F. 26 Sheldon Ave. S.E., Grand Rapids 2
Jensen, William B., Jr.....3147 Bonnell Ave. S.E., Grand Rapids
Johns, Donald C.....655 Broadview St. S.E., Grand Rapids 7
Johnston, Dan W.....2440 Beechwood S.E., Grand Rapids 6
Johnston, Wm. L.....245 State St. S.E., Grand Rapids 3
Jones, Edw. A.....346 Wealthy St., S. E., Grand Rapids
Jones, Haven E.....833 Lake Drive S.E., Grand Rapids
Jui, John O. L.....4234 Lake Mich. Dr. N.W., Grand Rapids 4
Kammeraad, L. A. (A).....33rd Sta. Hosp. APO 69, New York, N.Y.
Kelley, Donald E.....515 Lakeside Dr. S.E., Grand Rapids 6
Kempter, Albert H. 1200 Lake Dr. S.E., Grand Rapids 6
Kenney, Leo J.....456 Cherry St. S.E., Grand Rapids 3
Kessler, Dale L.....540 Belvedere Dr. S.E., Grand Rapids 6
Ketcham, Donn W. (A).....GPO Box 78, Chittagong, E. Pakistan
Kincaid, William E.....100 Michigan St. N.E., Grand Rapids 3
Klein, Jacob E. (M).....RR 2, Box 30, Bangor
Klein, Thomas (A)....623 Ottillia S.E., Grand Rapids 7
Klomparens, James T. 1662 Morningside, Grand Rapids
Klooster, Gerald 26 Sheldon Ave. S.E., Grand Rapids 2
Kniskern, Paul W.....26 Sheldon Ave. S.E., Grand Rapids 2
Koh, Nan Kyung 303 Ionia Ave. N.W., Grand Rapids 2
Kooistra, Henry P.....1564 Pontiac Rd., Grand Rapids 6
Kool, Bernard P.....445 Cherry St. S.E., Grand Rapids 3
Kreulen, Henry J.....2452 Godwin S.E., Grand Rapids 7
Krhovsky, Frank J.....153 Lafayette Ave. S.E., Grand Rapids 3
Krull, Edw. A.....255 Washington S.E., Grand Rapids 2
Kruse, Wm. T., Jr. (A).....255 Washington S.E., Grand Rapids 3
Kuiper, K. Van Zanten.....2208 Madison Ave. S.E., Grand Rapids 7

Laird, Robt. G.....26 Sheldon Ave. S.E., Grand Rapids
Lamberts, Austin E.....68 Ransom Ave. N.E., Grand Rapids 3
Lang, Ramon B.....1520 Plainfield Ave. N.E., Grand Rapids 5
Leep, Jos. H.....1036 Franklin St. S.E., Grand Rapids
Lentini, Jos. R.....110 Fulton St. S.E., Grand Rapids 2
Lewis, Geo. H.....30 Manchester Rd. S.W., Grand Rapids 8
Lieffers, Harry (L).....26 Sheldon Ave. S.E., Grand Rapids 2
Lincer, William T.....110 Fulton St. E., Grand Rapids 2
List, Carl F.....833 Lake Dr. S.E., Grand Rapids 6
Logie, James W. Ramona Medical Center, Grand Rapids
Lukens, Jack G.....245 State St. S.E., Grand Rapids 3

MacDonell, James A.....50 College Ave. S.E., Grand Rapids 3
MacIntyre, Dugald S.....515 Lakeside Dr. S.E., Grand Rapids 6
MacVicar, James E. (A).....Indiana Univ. Med. Cent., Indianapolis 7, Ind.
Mancewicz, Jerome F.....1154 Leonard St. N.W., Grand Rapids
Mann, Jos. D.....100 Michigan St. N.E., Grand Rapids 3
Marsh, John P.....124 Fulton St., S.E., Grand Rapids 2
Martinus, Martin.....124 Fulton St. E., Grand Rapids
Marvin, John A. 6850 Division Ave. S., Grand Rapids 8
Mason, Warren B. 50 College Ave. S.E., Grand Rapids 3
Maternowski, C. J.....515 Lakeside Dr. S.E., Grand Rapids 6
Maycroft, T. C. (A).....2660 Euclid Hgts. Blvd., Cleveland 6, Ohio
Maynard, Mason S.....445 Cherry St. S.E., Grand Rapids 3
McCormick, John K.....122 Caledonia N.E., Grand Rapids 5
McDougal, Wm. J.....127 Fountain St. N.E., Grand Rapids 3
McFarland, Jack O. (A).....2318 Gaynor N.W., Grand Rapids 4
McKay, Orval I.....311 E. Main St., Lowell
McKinlay, Leland M. (R).....Barnet, Vt.
Meade, Richard H., Jr. (A).....750 San Jose Drive, Grand Rapids 6
Meeuwsen, Bernard 26 Sheldon Ave. S.E., Grand Rapids
Mehney, Gayle H.....245 State St. S.E., Grand Rapids 3
Millard, James A. 894 Fuller Ave. N.E., Grand Rapids 3
Miller, David G. (A).....100 Michigan St. N.E., Grand Rapids 3

Miller, John J. (L).....1580 Water St., Marne
Miller, J. D.....50 College Ave. S.E., Grand Rapids 3
Miller, Theo. P.....833 Lake Drive S.E., Grand Rapids 6
Moberg, Carl H.....833 Lake Dr. S.E., Grand Rapids 6
Moen, Cornetta G.....215 Paris Ave. S.E., Grand Rapids
Moleski, Joseph V...26 Sheldon Ave. S.E., Grand Rapids
Moleski, Leo T.....26 Sheldon Ave. S.E., Grand Rapids
Moleski, Stanley L.....1701 Pontiac Dr., Grand Rapids
Moleski, Walter L. (A).....1701 Pontiac Rd. S.E., Grand Rapids 6
Moll, Arthur M.....74 Ionia Ave. N.W., Grand Rapids 2
Mollmann, Arthur H.....110 E. Fulton St., Grand Rapids
Montgomery, John C.....1810 Wealthy St. S.E., Grand Rapids 6
Moore, Douglas P.....515 Lakeside Dr. S.E., Grand Rapids 6
Morey, Edward C. (L)....613 Lake Ave., Franklin, Ohio
Mouw, Dirk R. 2352 Jefferson Dr. S.E., Grand Rapids 7
Mulder, G. Arthur.....1414 Eastern Ave. S.E., Grand Rapids 7
Mulder, Jacob D. (L).....6850 S. Division Ave., Grand Rapids 8
Muldoon, James P. 72 Sheldon Ave. S.E., Grand Rapids
Nahn, Charles E. (A).....Letterman Gen. Hosp. San Francisco, Calif.
Nanzig, Reinard P...153 Lafayette S.E., Grand Rapids 3
Newton, John P.....1660 Diamond Ave. N.E., Grand Rapids 5
Nickel, Kenneth C...833 Lake Drive S.E., Grand Rapids
Nienhuis, Herman D. (A).....827th Med. Gp. Bhl. AFB, Peru, Ind.
Noordhoff, M. Samuel (A).....N. Chun San Road, Taipei, Taiwan, Formosa
Northouse, Peter B.....26 Sheldon Ave. S.E., Grand Rapids 2
Notier, Victor A...50 College Ave., S.E., Grand Rapids 3
Oats, Saml. M.....245 State St. S.E., Grand Rapids 3
O'Brien, James D...1645 Webster N.W., Grand Rapids 4
O'Driscoll, Wm. G.....515 Lakeside Dr. S.E., Grand Rapids 6
Oliver, W. W. (L)..26 Sheldon Ave. S.E., Grand Rapids
Orders, Richard L.....255 Washington S.E., Grand Rapids 3
Outcalt, Herman A. (A).....4460 S.W. Scholls Ferry, Portland 25, Ore.
Overbeek, Ernest L. 26 Sheldon Ave. S.E., Grand Rapids
Paalman, Russell J.....26 Sheldon Ave. S.E., Grand Rapids 2
Palaszek, Theresa R.....833 Lake Dr. S.E., Grand Rapids
Pattullo, Marshall.....515 Lakeside Dr. S.E., Grand Rapids 6
Payne, C. Allen.....1840 Wealthy St., Grand Rapids
Pedden, John R.....445 Cherry St. S.E., Grand Rapids 3
Pilling, Warren C.....936 Orchard S.E., Grand Rapids 6
Piskin, M. S. (A).....750 Fuller N.E., Grand Rapids 3
Plekker, Johannes D. 833 Lake Dr. S.E., Grand Rapids 6
Pool, Lee R.....245 State St. S.E., Grand Rapids
Porter, Howard P.....833 Lake Drive S.E., Grand Rapids
Posthuma, Albert E. 153 Lafayette S.E., Grand Rapids 3
Postma, Edward Y.....245 State St. S.E., Grand Rapids 3
Postma, Howard F.....4130 Chicago Dr., Grandville
Potchen, E. James (A).....721 Huntington Ave., Boston 15, Mass.
Pott, Abraham L.....1011 Fulton St. E., Grand Rapids 3
Prothro, Winston B. 303 Ionia Ave. N.W., Grand Rapids
Puite, Robert H. 515 Lakeside Dr. S.E., Grand Rapids 6
Pusczak, George B. (A).....3265 Sondra Dr., Fort Worth, Texas
Raiman, Robert J.....50 College Ave. S.E., Grand Rapids
Ralph L. Paul.....953 Rosewood Drive S.E., Grand Rapids 6
Rasmussen, Richard A.....Blodgett Med. Bldg., Grand Rapids 6
Reardon, D. F.....1168 Nixon N.W., Grand Rapids 4
Reus, Wm. F.....24 Burton St. S.E., Grand Rapids 7
Reus, Wm. F., Jr.....153 Lafayette Ave. S.E., Grand Rapids 3
Riekse, James M.....2740 Eastern Ave. S.E., Grand Rapids 7
Rienstra, John C. (A).....347 Bostwick N.E., Grand Rapids 3
Ringenberg, J. C., 50 College Ave. S.E., Grand Rapids 3
Robb, Chas. S.....445 Cherry St. S.E., Grand Rapids 3
Robbert, John H.....3011 Wilson, Grandville
Robinson, Harold C.....26 Sheldon Avenue S.E., Grand Rapids 2
Rodgers, Wm. L.....616 Bridge N.W., Grand Rapids
Rooks, Wendell H.....1339 Plainfield N.E., Grand Rapids
Roosenberg, William.....3000 Monroe Ave. N.W., Grand Rapids
Rosenzweig, Leonard.....515 Lakeside Dr. S.E., Grand Rapids 6
Roth, Emil M.....604 Loraine Bldg., Grand Rapids 2
Roth, Wm. J. (A).....303 W. Superior, Alma
Rupp, Theo. J.....50 College Ave. S.E., Grand Rapids 3
Russcher, Allan H. (A)..525 Grand Pre Ave., Kalamazoo
Ryan, John A.....153 Lafayette S.E., Grand Rapids 3
Ryskamp, James J., Jr. (A).....11423 Fair Oak Dr., Silver Springs, Md.
Santinga, John T. (A)..1424 Kensington Dr., Ann Arbor
Schaubel, Howard J...124 Fulton St. E., Grand Rapids 2
Schek, Donald C.....2749 Clyde Park S.W., Grand Rapids 8
Schermerhorn, L. J. (R).....2317 Vine Hill Rd., Santa Cruz, Calif.
Schilling, R. J.....833 Lake Drive S.E., Grand Rapids 6
Schlosser, Ralph J.....456 Cherry St., Grand Rapids 3
Schneider, Geo. R.....1810 Wealthy St. S.E., Grand Rapids 6
Schnoor, Elmer W.....844 Iroquois Drive S.E., Grand Rapids 6
Schnute, Louise F.....146 Monroe N.W., Grand Rapids 2
Schwaderer, Thos. G. (A).....100 Michigan St. N.E., Grand Rapids 3
Scott, Wm. B.....26 Sheldon Ave. S.E., Grand Rapids 2
Sculley, Raymond E.....20 Burton S.E., Grand Rapids 7
Seime, Reuben I.....201 Lafayette S.E., Grand Rapids
Sevensma, Elisha S. (L).....1077 Leonard N.E., Grand Rapids
Sevensma, Eugene S...1077 Leonard N.E., Grand Rapids
Sharda, Martin.....740 Alger St. S.E., Grand Rapids
Sharp, Robert B.....833 Lake Dr. S.E., Grand Rapids 6
Sidell, Richard H.....515 Lakeside Dr. S.E., Grand Rapids 6
Siebers, Bernard H.....1085 Leonard N.E., Grand Rapids
Sikkema, Donald E. (A).....6674 Clyde Park Ave., Grand Rapids
Skendzel, L. P. (A)..General Hospital, Indianapolis, Ind.
Sluyter, John S.....2740 Eastern S.E., Grand Rapids 7
Smith, Dean B.....245 State St. S.E., Grand Rapids
Smith, John H.....1840 Wealthy St. S.E., Grand Rapids 6
Smith, Robt. B.....26 Sheldon Ave. S.E., Grand Rapids 2
Smith, R. Earle (L).....74 Ionia Ave. N.W., Grand Rapids 2
Snider, John D.....2130 Godwin Ave. S.E., Grand Rapids
Snider, Ralph E. (A).....430 Gladstone Ave. S.E., Grand Rapids 6
Snyder, Clarence A. (A).....2463 College Ave. S.E., Grand Rapids 7
Snyder, Clarence H.....500 Cherry St. S.E., Grand Rapids 3
Southwick, C. H...515 Lakeside Dr. S.E., Grand Rapids 6
Southwick, G. Howard....515 Lakeside S.E., Grand Rapids
Sprague, Wm. E. 1039 Fulton Street W. Grand Rapids 4
Starr, Charles R...26 Sheldon Ave. S.E., Grand Rapids 2
Steffensen, W. H.....1810 Wealthy St. S.E., Grand Rapids
Stonehouse, Garnet G. (R).....408 Medical Arts Bldg., Grand Rapids 2
Stoneman, Fernley.....3011 Wilson, Grandville
Stover, Virgil E.....860 Gladstone S.E., Grand Rapids 6
Strong, Leroy E.....515 Lakeside Dr. S.E., Grand Rapids 6

Stuart, Gerhardus J. (L).....1140 Keystone Ave., River Forest, Ill.
Sugg, Cullen E.....303 Fulton St. E., Grand Rapids 3
Sugiyama, Tetsuo.....110 E. Fulton St., Grand Rapids 2
Sun, Keh Ming....St. Marys Hosp. Lab., Grand Rapids 3
Sus Strong, Carl A. (R).....316 Union Ave. S.E., Grand Rapids
Swan, Jerome W...26 Sheldon Ave. S.E., Grand Rapids 2
Swanson, Alfred B.....1810 Wealthy St. S.E., Grand Rapids 6
Swenson, Harold C...124 Fulton St. E.....Grand Rapids 2

Telego, A. J.....2505 Fletcher Dr. N.E.....Grand Rapids 6
Ten Have, John..3515 Briggs Blvd. N.E., Grand Rapids 2
Ter Keurst, Donald H.....2402 Eastern Ave., S.E., Grand Rapids 7
Tesseine, Arthur J.....1328 Madison S.E., Grand Rapids 7
Teusink, James H.....Cedar Springs
Theodore, Paul G.....1520 Plainfield Ave. N.E., Grand Rapids 5
Thompson, Athol B.....1810 Wealthy St. S.E., Grand Rapids 6
Thompson, Edward C.....153 Lafayette Ave. S.E., Grand Rapids 3
Thompson, Frank D.....4011 Reeds Lk. Blvd. S.E., Grand Rapids 6
Tidey, Marcus B. (A).....7157 Wildermere Dr. N.E., Rockford
Tiffany, Jos. C.....2322 Jefferson Dr. S.E., Grand Rapids 7
Torgerson, Wm. R.....Ramona Medical Center, Grand Rapids
Torgerson, Wm. R., Jr.....515 Lakeside Dr. S.E. Grand Rapids 6
Townsend, Jack H.....515 Lakeside Dr. S.E., Grand Rapids 6
Troske, Robt. L. (M)..26 Foster Circle, Ft. Rucker, Ala.
Truog, Clarence P.....110 Fulton St. E., Grand Rapids 2
Turcotte, V. J., Jr.....515 Lakeside Dr. S.E., Grand Rapids 6

Valdmanis, Ferdinands.....2120 Lake Dr. S.E., Grand Rapids
Van Bree Raymond S.....812 Rosalie N.W., Grand Rapids 4
Vanden Berg, A. R...833 Lake Dr. S.E., Grand Rapids 6
Vanden Berg, Henry J. (L).....2933 Bonnell Road S.E., Grand Rapids
Vanden Berg, Wm. O.....50 College Ave. S.E., Grand Rapids 3
Vander Kolk K. J.....2740 Eastern Ave. S.E., Grand Rapids 7
Vander Meer, Raymond.....26 Sheldon Ave. S.E., Grand Rapids 2
Vandermolen, John....124 Fulton St. E., Grand Rapids 2
Vander Ploeg, R. A. 153 Lafayette S.E., Grand Rapids 3
Vander Ploeg, Wm. H.....833 Lake Dr. S.E., Grand Rapids 6
Van Der Veer, Corwin G.....245 State St. S.E., Grand Rapids 3
Van Dommelen, G. M.....456 Cherry St. S.E., Grand Rapids 3
Van Duine, Henry J.....153 Lafayette S.E., Grand Rapids 3
Van Dyke, Harold E.....1108 Leonard St. N.E., Grand Rapids
Van Etten, Donald D. (A).....220 Union Ave. N.E., Grand Rapids 3
Van Goor, Kornelius.....26 Sheldon Ave. S.E., Grand Rapids 2
Van Noord, Gelmer A.....6850 Division Ave. S., Grand Rapids 8
Van Portfliet, Paul....245 State St. S.E., Grand Rapids 3
Vansolkema, Andrew A.....953 E. Fulton St., Grand Rapids
Van't Hof, Albert..50 College Ave. S.E., Grand Rapids 3
Van Vliet, Peter D. (A).....1416 Berkman Ct. S.W., Rochester, Minn.
Van Woerkom, Danl.....933 Leonard St. N.W., Grand Rapids 4
Van Zwalenburg, B. R.....2054 Anderson Dr. S.E., Grand Rapids 6
Vasu, C. Mark (A).....465 Tuttle N.E., Grand Rapids
Veldman, Harold E.....26 Sheldon Ave., Grand Rapids 2
Veltman, Jay H.....3946 G. 30th St., Grandville
Venema, Jay R.....540 Overbrook Lane S.E., Grand Rapids 7
Ver Lee, Jimmie J. (A).....Galmi Hospital, Galmi Via Madaoua, Nigeria Republic, West Africa
Ver Meulen, John (L).....2400 Wyoming, Grand Rapids
Ver Meulen, Peter (A).....105 Baynton N.E., Grand Rapids
Verwys, A. L. Hubert.....815 Alger St. S.E., Grand Rapids 7
Vining, Keats K., Jr.....515 Lakeside Dr. S.E., Grand Rapids
Vis, William R. (L).....26 Sheldon Ave. S.E., Grand Rapids 2
Visscher, H. C.....515 Lakeside Dr. S.E., Grand Rapids 6
Visser, Earl R.....124 Fulton St. E., Grand Rapids 2
Vogel, Anton.....1204 Madison Ave. S.E., Grand Rapids
Voss, John A.....2060 Alpine Ave. N.W., Grand Rapids 4
Vroon, John.....50 College Ave. S.E., Grand Rapids 3
Vyn, Jay D.....7119 Driftwood S.E., Grand Rapids 6

Wahby, Elmer F. 300 Bostwick Ave. N.E., Grand Rapids
Walma, Daniel (A).....5762 Cadillac Dr., Indianapolis 24, Ind.
Wassink, Roger N. (A)..720 S. Wolcott, Chicago 12, Ill.
Waterman, Donald F.....515 Lakeside Dr. S.E., Grand Rapids
Webb, Clarence F.....833 Lake Dr. S.E., Grand Rapids 6
Webber, Jerome E.....50 College Ave. S.E., Grand Rapids 3
Weeber, Thomas A.....3011 Wilson S.W., Grandville
Weller, Keith E.....1200 Lake Dr. S.E., Grand Rapids 6
Wells, S. Merrill, Jr. (L).....2716 Bonnell Dr. S.E., Grand Rapids 6
Wenger, Aaron V. (L).....132 Grand Ave. N.E., Grand Rapids
Wenger, John N. (L)..112 Eastmanville St., Coopersville
Westendorp, Floyd.....6850 Division Ave. S., Grand Rapids 8
Westerhoff, Robert J.....2740 Eastern Ave. S.E., Grand Rapids
Whinery, Jos. F.....50 College Ave. S.E., Grand Rapids 3
Whitehouse, John D.....1201 Colorado Ave. S.E., Grand Rapids 6
Whittenberger, R. N.....245 State St. S.E., Grand Rapids 3
Wiese, John L.....50 College Ave. S.E., Grand Rapids 3
Wilderom, Morris.....303 Ionia Ave. S.W., Grand Rapids
Wilkes, John B.....1328 Madison Ave. S.E., Grand Rapids 7
Wilkinson, C. A...2030 Leonard St. N.W., Grand Rapids
Williams, John R.....1111 Conlon S.E., Grand Rapids 6
Wilson, John R.....1033 Fulton St. West, Grand Rapids
Wilson, R. J.....2060 Alpine N.W., Grand Rapids 4
Wilson, Wm. E. (R).....37 Prospect Ave. N.E., Grand Rapids
Winfield, Emery D.....457 Burton S.E., Grand Rapids
Winter, Garrett E.....1967 Godfrey Ave. S.W., Grand Rapids 9
Wright, Thos. B.....2614 Plainfield Ave. N.E., Grand Rapids 8
Wurz, John F...201 Norwood Ave. S.E., Grand Rapids 6
Wyngaarden, Martin K.....245 State St. S.E., Grand Rapids 3

Yared, Jerome A.....651 Cherry St. S.E., Grand Rapids 6
Yost, William G., Jr.....50 College Ave. S.E., Grand Rapids 3

Zadvinskis, Z.....833 Lake Dr. S.E., Grand Rapids
Zwemer, Rodger J.....1810 Wealthy St. S.E., Grand Rapids

LAPEER COUNTY MEDICAL SOCIETY (110)

Abruzzo, Anthony M.....Lapeer State Home, Lapeer
Bishop, G. Clare.....Almont
Boruch, Leon R.....Drawer A, Lapeer St. Hme., Lapeer
Buchanan, Thos. K. (A)....Ypsilanti St. Hosp., Ypsilanti
Conaway, Chas. E.....746 Monroe St., Lapeer
Dorland, Clarke.....221 Lincoln St., Lapeer
Doty, James R.....315 Clay St., Lapeer
Greavu, Cornell, Jr.....North Branch
Heitsch, Wm. C.....307 Clay St., Lapeer
House, Clifford.....1026 N. Madison, Lapeer
Kiehler, E. G., II.....1444 W. Genesee St., Lapeer
Kocur, Lubomira.....Drawer A, Lapeer St. Home, Lapeer
Lebedovych, Emil....Drawer A, Lapeer St. Home, Lapeer
Lebedovych, Ksenia Drawer A, Lapeer St. Home, Lapeer
Leith, Dorothy L.....240 Main St., Imlay City
Lynk, Stanley M.....4589 Lippincott, Lapeer
McBride, John R.....431 Washington St., Lapeer
Panczak, Tamara (A).....3952 Evaline, Detroit 12
Smith, Ellen.....400 White Rd., R. 1, Columbiaville
Smith, Glenn L.....6552 Imlay City Rd., Imlay City
Utley, Marvin (A).....Box 900, Elkton, Md.
Zemmer, H. R. (A).....Lapeer
Zolliker, Carl R. (R).....3646 Slattery Rd., Lum

LENAWEE COUNTY MEDICAL SOCIETY (114)

Abraham, A. O.....Hudson
Armovit, Herminio.....236 S. Fourth St., Onsted
Benz, Carl A.....308 N. Broad St., Adrian
Berghuis, John.....693 Stockford Dr., Adrian
Blanchard, Lowell E.....Hudson
Blanden, Merwin R.....Tecumseh
Boyd, James W.....4510 Southgate Lane, Adrian
Claxton, Wilbert T.....Britton
Coak, Richard D.....Herrick Memorial Hosp., Tecumseh
Cook, Carlton L.....W. Chicago Rd., Tecumseh
Diccion, R. A.....Addison
Dickman, Harry M.....104 Oak St., Hudson
Dustin, Richard E.....103 W. Brown St., Tecumseh
Eddy, Howard R. C.....Mill Rd., Adrian
Feeney, James L.....Mill St., Adrian
Fitzsimmons, Francis J.....128 E. Butler St., Adrian
Gilkey, William C.....693 Stockford Drive, Adrian
Gilmartin, Richard.....Mill St., Adrian
Greiner, Robert A.....Professional Bldg., Adrian
Hammel, Richard T.....Tecumseh
Hammersley, Gordon.....1361 Oregon Rd., Adrian
Harrison, Robt. E.....418 W. Adrian, Blissfield
Heffron, Chas. H.....231 N. Main St., Adrian
Heffron, C. Harold (A).....231 N. Main St., Adrian
Heffron, Howard H.....231 N. Main St., Adrian
Helzerman, Ralph F.....112 S. Ottawa St., Tecumseh
Hewes, Wm. H.....Mill Rd., Adrian
Hinshaw, Warren V. (A).....139 N. Main St., Adrian
Locke, Francis A.....767 W. Maumee, Adrian
Marsh, Roland G. B.....610 W. Logan St., Tecumseh
Miller, P. Lynford.....310 E. Maumee St., Adrian
Ocamb, Harold D.....900 West Chicago, Tecumseh
O'Connor, Archie R.....122 Locust St., Clinton
Parker, Donald A.....4396 Evergreen Dr., Adrian
Patmos, Bernard.....127 E. Maumee St., Adrian
Phelan, Alvin J.....10 Cairns, Tecumseh
Raabe, Elmer C.....Morenci
Richey, Bert R.....765 Manitou Rd., Manitou Beach
Rogers, John D.....146 Toledo St., Adrian
Sarapo, Donato F.....Mill St., Adrian
Skufis, Eleanor P.....774 College Ave., Adrian
Skufis, Xenophon.....123 E. Chestnut, Adrian
Stark, Emily S. (A).....513 E. Front St., Adrian
Stewart, Landis C.....750 High St., Adrian
Tubbs, Ray V. (A).....120 E. Adrian, Blissfield
Van Dusen, Chad A. (L).....RFD 5, Blissfield
Wentz, Patricia.....760 Riverside, Adrian
Whitehouse, Keith H.....Morenci
Wilson, Geo. C.....Box 224, Clinton
Wolf, Marvin B.....689 Stockford Dr., Adrian
Wynn, Geo. H.....1115 W. Maumee, Adrian

LIVINGSTON COUNTY MEDICAL SOCIETY (118)

Barton, Thos. A.....116 N. Michigan, Howell
Chelsky, Morris.....116 W. Grand River, Brighton
Clarke, Niles A.....624 Spencer Rd., Brighton
Damstra, Donald L.....12893 E. Grand River, Brighton
Duffy, Ray M. (L).....Box 106, Pinckney
Fidler, Wm. F.....Mich State Sanitarium, Howell
Harebottle, Norman.....Fowlerville
Hauer, R. Fred.....Fowlerville
Hendren, Jesse J. (R).....Fowlerville
Higby, Thomas F.....Fowlerville
Hill, Harold C.....116 N. Michigan Ave., Howell
Hoffman, Stanley L.....1200 Byron Road, Howell
Perry, Florence J. C.....17640 San Rose Ave., Lathrup Village
Phillips, R. W.....Hamburg
Polack, Robt. T.....1223 Thruber Dr., Howell
Schenden, A. J. (R).....6335 W. M-36, Pinckney
Sheng, Luke H. C.....111 W. Grand River, Brighton
Smith, Russell F.....9569 Main St., Whitmore Lake
Stuber, Roscoe V.....1200 Byron Rd., Howell
Walker, Enos G.....4485 Cordley Lake, Lakeland
Wang, Stella K. C.....111 Grand River, Brighton
Woodworth, Edwin S.....1200 Byron Rd., Howell

LUCE COUNTY MEDICAL SOCIETY (122)

Cameron, Richard R.....Newberry State Hosp., Newberry
Gibson, Robt. E. L., Jr.....207 W. John St., Newberry
Grennan, Lawrence E.....Newberry
Hicks, R. P.....210 W. John St., Newberry
Purmort, Wm. R., Jr.....Newberry State Hosp., Newberry
Surrell, Matthew A.....210 W. John St., Newberry
Thompson, Thos. W.....Newberry State Hosp., Newberry

MACOMB COUNTY MEDICAL SOCIETY (126)

Adler, Morton W.....19188 Appoline St., Detroit 35
Alexander, James H.....25815 Harper, St. Clair Shores
Ambrose, Robt. H.....18801 E. Ten Mile Rd., Roseville
Arellano, Miguel A.....11868 E. Eleven Mile Rd., Warren
Audretsch, F. E.....36275 Alfred, New Baltimore
Barker, John G.....8050 Warren Blvd., Center Line
Beecher, Alvin J.....21501 Kelly, East Detroit
Biluk, Frank J.....GM Tech. Center, Warren
Bond, Franklyn F.....4861 E. Nine Mile Rd., Warren
Bower, Allen B. (L).....Armada
Bryce, James W.....25219 Van Dyke Ave., Center Line
Buckley, Danl. J.....160 S. Walnut St., Mount Clemens
Chabator, George.....294 Benjamin St., Romeo
Charbeneau, Harold P.....229 S. Gratiot, Mt. Clemens
Charbonier, Luis M...11868 E. Eleven Mile Rd., Warren
Clay, Joel, W.....263 S. Gratiot Ave., Mt. Clemens
Cohen, Allen.....19750 Stansburg, Detroit
Colah, Sorab A...708 Monitor Leader Bldg., Mt. Clemens
Collon, David, D.D.S. (A).....Romeo
Corbett, John.....225 S. Gratiot, Mt. Clemens
Cosio, Jose.....St. Joseph Hospital, Mt. Clemens
Courtney, Rufus S.....St. Joseph Hosp., Mt. Clemens
Croman, Jos. M., Jr.....115 Cass Ave., Mt. Clemens
Curatolo, Victor.....67 Cass Ave., Mt. Clemens
Darian, H. B.....11528 E. 12 Mile Rd., Warren
Deal, Harold R.....23700 Van Dyke, Warren
Depaulis, Dario C.....22644 Gratiot, East Detroit
Dudzinski, Edmund J.....424 Washington St., New Baltimore
Ebner, Charles M.....26401 Harper, St. Clair Shores
Ekelman, Seymour B.....14 Belleview, Mt. Clemens
Ellias, Elmer P.....23700 Van Dyke, Warren
Engels, John A.....69311 N. Main, Richmond
Erkfitz, Arthur W.....26401 Harper Ave., St. Clair Shores
Finn, James Wm.....46056 Cass, Utica
French, Lawrence W.....25815 Harper, St. Clair Shores
Fulgenzi, Andrew A.....17301 E. Eight Mile Rd., East Detroit
Gerbasi, Francis.....81 Lochmoor Blvd., Grosse Pte. Shs.
Gesser, Charles.....20914 Kelly Road, East Detroit
Goldin, Morris I.....6902 Chicago Rd., Warren
Goldman, Bernard J.....243 S. Gratiot Ave., Mt. Clemens
Hartmann, Waldemar B.....1416 S. Gratiot, Mt. Clemens
Hiller, Herbert M.....13500 E. Twelve Mile Rd., Warren
Horvath, Julius.....18019 Holland Ave., East Detroit
Hranchook, Michael.....30001 Van Dyke, Warren
Hull, Frank J.....Monitor Leader Bldg., Mt. Clemens
Iglesias, Ernesto R.....608 Monitor Leader Bldg., Mt. Clemens
Isbey, Edward K.....25020 Van Dyke, Center Line
Ivkovich, Peter (A).....12501 E. 23 Mile Rd., Utica
Jacobs, Manuel.....23700 Van Dyke Ave., Warren
Jewell, James H.....Roseville Theatre Bldg., Roseville
Kane, John P.....67 Cass Ave., Mt. Clemens
Kane, Peter V.....67 Cass Ave., Mt. Clemens
Kane, Wm. J. (L).....69 Cass Ave., Mt. Clemens
Kingsley, Joyce W., Jr.....18801 Ten Mile Rd., Roseville
Kirker, J. G.....68259 Main St., Richmond
Kirtland, Wm. B., Jr.....18801 E. Ten Mile Rd., Roseville
Klein, Alfred A.....23700 Van Dyke, Warren
Kommel, Richard M.....13134 Talbot, Huntington Woods
Kripke, Morton J.....52080 Van Dyke, Utica
Kroon, Joseph D.....37984 Bonkay, Mt. Clemens
Kurtz, Hyman.....13087 E. Eleven Mile Rd., Warren
Kypros, George P.....26401 Harper St., St. Clair Shores
Laporte, Lawrence A.....1238 Tawas Beach Rd., East Tawas
Lapp, Charles.....7817 McClellan, Utica
Levi, Charles.....8262 E. Twelve Mile Rd., Warren
Lublin, Ann.....21349 Kelly Rd., East Detroit
MacGuire, Andrew J.....45569 Van Dyke, Utica
Mark, Hansi,.....8236 E. 12 Mile Rd., Warren
Martin, Wm. L.....117 S. Main St., Romeo
Mattes, Max W.....18456 Wildemere, Detroit 21
Matthews, C., Jr.....14 Belleview, Mt. Clemens
Maxim, Edward S.....253 South Gratiot, Mt. Clemens
McGinty, John D.....243 S. Gratiot, Mt. Clemens
McMorrow, Kathryn..15341 Nine Mile Rd., East Detroit
McRae, Cameron F.....43525 Elizbeth Rd., Mt. Clemens
Merametdjian, Krikor.....8276 Cadillac, Warren
Merritt, Jule J.....36640 S. Gratiot Ave., Mt. Clemens
Metropoulos, S. G.....11600 Meadowbrook Dr., Warren
Miller, Sidney S.....28477 Hoover Rd., Warren
Moore, Geo. F. (L).....67 Cass Ave., Mt. Clemens
Morris, Gerald W.....14 Belleview, Mt. Clemens
Mulligan, Philip T.....612 Monitor Leader Bldg., Mt. Clemens
Nance, Marion E.....16666 14 Mile Rd., Fraser
Neiswander, Paul L.....Fisher Body Div. GMC, Warren
Nutting, Helen M. 22631 Greater Mack, St. Clair Shores
Ornstein, Chas.....21701 Kelly Rd., E. Detroit
O'Shee, Vincent.....8216 E. Twelve Mile Rd., Warren
Oughtred, Orville.....26401 Harper, St. Clair Shores
Pacho, Marc.....27075 Gail, Warren
Paris, Delmo A.....18801 E. Ten Mile Rd., Roseville
Parmelee, N. H.....26758 Gratiot, Roseville
Perez, Florence.....27075 Gail, Warren
Reichman, Jos. J.....67 Cass Ave., Mt. Clemens
Reitzel, Rufus H.....199 S. Gratiot Ave., Mt. Clemens
Reizen, Maurice S.....10564 Ludlow, Huntington Woods
Revere, Jos. O.....192 S. Gratiot Ave., Mt. Clemens
Riddle, Charles B.....620 East Land Prof. Bldg., Harper Woods
Rinkenberger, E. A.....243 S. Gratiot Ave., Mt. Clemens
Rivard, Charles L.....20825 Mack Ave., Grosse Pte. Woods 36
Rivkin, Jos.....14 Belleview, Mt. Clemens
Rizzo, Albert.....21321 Harper, St. Clair Shores
Rooney, Robert.....23700 Van Dyke, Warren
Roth, Geo. E.....19136 Mendota Ave., Detroit 21
Rothman, Arthur M.....22422 Gratiot Ave., East Detroit
Rourke, Ronald E.....21503 Harper Ave., St. Clair Shores
Rousseau, Daniel L...Monitor Leader Bldg., Mt. Clemens
Ruedisueli, C. A.....19 Breitmeyer Pl., Mt. Clemens
Rush, Wm. E.....25815 Harper, St. Clair Shores
Ryan, Jack.....23700 Van Dyke Ave., Warren
Salot, Russell F.....67 Cass Ave., Mt. Clemens
Scher, Jos. N.....130 Cass Ave., Mt. Clemens
Scher, Sydney.....132 Cass Ave., Mt. Clemens
Schmunk, Robert F.....136 Cass Ave., Mt. Clemens
Sherbin, Herbert D.....12500 Twelve Mile Rd., Warren
Siegfried, Edward G.....229 S. Gratiot Ave., Mt. Clemens
Sims, Wm. N.....229 S. Gratiot, Mt. Clemens
Singer, Nelson.....22100 Gratiot Ave., East Detroit
Smith, Milton C. (L)....60 S. Gratiot Ave., Mt. Clemens
Stanton, James.....225 S. Gratiot, Mt. Clemens
Starbird, Wm. A.....8216 E. 12 Mile Rd., Warren
Starkman, Morris.....28477 Hoover, Warren
Steele, George H.....229 S. Gratiot, Mt. Clemens
Steinberger, Eugene.....23700 Van Dyke, Warren
Stepka, Joseph E.....7817 McClellan, Utica
Stief, Kirwin.....66 Riverview, Mt. Clemens
Stone, Elizabeth A.....Romeo
Stone, Julius.....67 Cass Ave., Mt. Clemens
Stone, Sanford.....4050 E. 12 Mile Rd., Warren
Strempek, Walter F. (A).....726 Whitehills Dr., East Lansing
Stryker, Oscar D.....43525 Elizabeth Rd., Mt. Clemens
Sturm, Fredk. A.....76 Lochmoor, Grosse Pointe 36
Suksta, Adolph W.....23250 Gratiot, East Detroit
Suzuki, M.....23700 Van Dyke, Warren
Thompson, Alfred A.....126 Cass Ave., Mt. Clemens
Tinkey, L. Leo.....8306 Twelve Mile Rd., Warren
Trinkaus, Wm. F.....22033 Kelly Road, East Detroit
Urbancic, William.....24605 Almond, East Detroit
Weiss, Jack I.....23700 Van Dyke Ave., Warren
Whitley, Alec.....30233 Jefferson Ave., St. Clair Shores

Wiley, D. Bruce.....46056 Cass Ave., Utica
Witus, Carl.....21349 Kelly Rd., East Detroit
Wolf, Ervin.....17819 Homer St., Roseville
Wyte, Wm. C.....263 S. Gratiot Ave., Mt. Clemens
Yamasaki, Ken.....23700 Van Dyke, Warren
Zavela, Dan.....679 N. Renaud, Grosse Pte. Wds.
Zook, Gilbert E., Mr. (A)....253 S. Gratiot, Mt. Clemens

MANISTEE COUNTY MEDICAL SOCIETY (130)

Futterer, LeRoy A.....Forest Clinic Bldg., Manistee
Garneau, Robt. R.....Forest Clinic Bldg., Manistee
Gunderson, Edw. P., Jr.....Greenbush Street, Manistee
Hansen, Ernest C.....326 First St., Manistee
Kiley, James A.....Forest Clinic Bldg., Manistee
Konopa, John F.....57 Poplar St., Manistee
Lalime, Ruth E. (A).....Box C, Traverse City
Miller, Ernest B.....326 First St., Manistee
Oakes, Ellery A. (R).....576 Bryant Ave., Manistee
Ramsdell, Homer A. (L).....398 River St., Manistee
Rosenow, K. G.....Forest Clinic Bldg., Manistee
Schwarz, Marlowe L.....Onekama
Schwing, Donald N.....Forest Clinic Bldg., Manistee
Wild, David A.....Forest Clinic Bldg., Manistee

MARQUETTE-ALGER COUNTY MEDICAL SOCIETY (134)

Acocks, James R.....Morgan Hgts. Sanat., Marquette
Amolsch, Arthur L.....1008 Bluff St., Marquette
Bennett, Arthur K. (L).....Box 436, Mt. Dora, Fla.
Bennett, Matthew C.....Medical Building, Marquette
Berry, Robt. F.....Medical Building, Marquette
Bertucci, Jos. P.....114 S. First St., Ishpeming
Bolitho, Thos. B.....Medical Bldg., Marquette
Breen, Donald J. (M).....56th USAF Hospital, KI Sawyer AFB, Gwinn
Carefoot, Rankin L.....St. Lukes Hospital, Marquette
Carter, James M.....Medical Building, Marquette
Casler, Wilbur L. (L).....131 E. Ridge St., Marquette
Celori, Luciano.....315 N. Front St., Marquette
Conley, Donal T.....1st Natl. Bank Bldg., Marquette
Cooperstock, Moses.....Medical Building, Marquette
Corcoran, Wm. A.....200 S. Main Street, Ishpeming
D'Adesky, R. G.....125 W. Washington, Marquette
Drom, Robert E.....Marq. Branch Prison, Marquette
Drury, Chas P. (R).....416 E. Hewitt Ave., Marquette
Elzinga, Eugene R.....315 N. Front St., Marquette
Erickson, Douglas W.....Ishpeming Hospital, Ishpeming
Grain, Gerald O.....R. 1, Box 1200, Marquette
Granger, David W., Jr. (M).....56th USAF Hosp., KI Sawyer AFB, Gwinn
Green, Southgate J.....Gwinn
Hettle, Paul J.....211 Savings Bank Bldg., Marquette
Hornbogen, Danl. P.....101 S. Front St., Marquette
Howe, Lloyd W. (L).....101 S. Front St., Marquette
Huffman, Elston R.....427 W. College, Marquette
Hulse, Robert C.....210 E. Superior St., Munising
Humphrey, William C.....829 Croix Street, Negaunee
Jaedecke, Robt. G.....829 Croix, Negaunee
Kane, Elizabeth D.....418 W. Magnetic, Marquette
Kloster, Ronald M. (M).....56th Dispensary, KI Sawyer AFB, Gwinn
Knutson, Geo. O. (A).....125 E. Main St., Negaunee
Koenig, Harry.....116 S. Main St., Ishpeming
Kronschnabel, E. F.....Medical Bldg., Marquette
Lambert, Warren C.....Medical Building, Marquette
Lindquist, Leo A.....Medical Bldg., Marquette
Lyons, James W.....803 N. 3rd St., Marquette
Matthews, Norman L...N. Mich. Child Clinic, Marquette
McCarthy, Jos. S. (L)....1521 Gull Lake Rd., Kalamazoo
Mudge, Thomas J.....Medical Building, Marquette
Mudge, Wm. A. (L).....108 Ridge St., Negaunee
Narotzky, Archie S.....Miracle Circle, Ishpeming
O'Brien, Francis D. (M).....242 Fortress, KI Sawyer AFB, Gwinn
Olson, Walter R.....108 E. Munising Ave., Munising
Paine, Raymond L.....416 Teal Lake Ave., Negaunee
Pearson, Wallace G. (M).....500 Envader St., KI Sawyer AFB, Gwinn
Ponischil, Carl J.....2962 Mackin Rd., Flint 4
Rankin, Harold C. (M).....KI Sawyer AFB, Gwinn
Rosenbaum, Louis.....540 E. Division, Ishpeming
Sabin, Fredk. C.....101 S. Front St., Marquette
Schmidt, Merle C. (A).....Medical Bldg., Marquette
Schroeder, W. Gene.....745 Mathe Ave., Ishpeming
Schweinsberg, Sara K. D. (A).....507 Bemis Rd., R.F.D., Saline
Strum, Gerald (M).....56th USAF Hospital, KI Sawyer AFB, Gwinn
Tearnan, Raymond A. (L).....Munising
Tobin, James F., Jr.....630 Wabash St., Ishpeming
Van Riper, Paul (L).....Champion
Williams, Reginald G.....524 Mather St., Ishpeming
Wilson, George M., Jr.....Medical Building, Marquette
Wright, Kenneth C.....Medical Building, Marquette

MASON COUNTY MEDICAL SOCIETY (138)

Bacon, Herbert G., Jr.....101 N. Main, Scottville
Boldyreff, Ephraim B.....Custer
Boon, A. Floyd.....203 N. Ferry, Ludington
Carney, John R.....202 N. Park St., Ludington
Carney, Ruth V. C.....202 N. Park Ave., Ludington
Castellani, R. J.....P.O. Box 349, Ludington
Clark, Harry L. (L)....510 N. Lakeshore Dr., Ludington
Craymer, Austin.....420 N. Rath, Ludington
Ewing, R. L.....600 Tinkham Ave., Ludington
Hoffman, Howard B...604 E. Ludington Ave., Ludington
Kelawan, Karl Scottville
Kleinschmidt, Gladys J.....401 E. Ludington Ave., Ludington
Martin, Wm. S.....107 Ludington, Ludington
Mayer, Gerry.....600 Tinkham Ave., Ludington
Morrow Wm. J.....119 N. James St., Ludington
Ostrander, Robt. A.....Lakewood Dr., C7, Ludington
Paukstis, Chas. A.....111 E. Court St., Ludington
Sutter, Wm. F.....220 S. James St., Ludington

MECOSTA-OSCEOLA-LAKE COUNTY MEDICAL SOCIETY (142)

Bruggema, Jacob.....Main St., Evart
Franklin, Benj. L. (L).....Remus
Haldeman, Jack.....1014 S. State St., Big Rapids
Hickox, Leland A.....1014 S. State St., Big Rapids
Ivkovich, Paul.....Reed City
Kilmer, Paul B.....Reed City
Kowaleski, Edward H.....Remus
Lincoln, Norman V.....Reed City
Merlo, Frank A.....206 S. Michigan St., Big Rapids
Nelson, Lorenzo R.....R.F.D. 1, Baldwin
Pratt, Gordon C.....Ferris Institute, Big Rapids
Tyson, James L.....1014 South State St., Big Rapids
Van Auken, Edward W.....229 S. Warren, Big Rapids
Walters, James E.....1014 S. State St., Big Rapids
Waun, James E.....925 7th Ave., Iowa City, Iowa
White, John A.....121 S. Michigan St., Big Rapids

MEDICAL SOCIETY OF NORTH CENTRAL COUNTIES (150)

Backe, John C. (R).....6401 N. Fifth Ave., St. Petersburg, Fla.
Baker, Ophelia P.....199 Fairview, West Branch
Baker, Thomas A.....199 Fairview, West Branch
Barstow, Richard G.....Gaylord
Blaha, Vernon B.....Grayling
Boehm, John D. (R).....West Branch
Bontrager, W. E.....Mio
Christensen, D. E.....N. Mich. TB San., Gaylord
Clippert, C. G.....308 Michigan Ave., Grayling
Coulter, Keith D.....Box 138, Alden
Crandell, Clare H. (R).....West Branch
Dosch, Paul.....Grayling
Forney, Fred A. (L)
Godfroy, Bernard.....Roscommon
Hasty, Earl A.....West Branch
Hayes, Louis F.....Gaylord
Henig, Benj. E.....Grayling
Howarth, Thos. W.....Gladwin
Jardine, Hugh M.....West Branch
Libke, Robert S.....Gaylord
Oppy, Charles L.....Roscommon
Peckham, Richard C.....Gaylord
Rusak, R. D.....Gladwin
Schaiberger, Geo. L.....West Branch
Stealy, Stanley A.....Grayling
Timreck, Harold A.....Gladwin
Van Oosten, Howard E.....117 Burgess, West Branch
Wiegerink, L. T.....West Branch

MENOMINEE COUNTY MEDICAL SOCIETY (146)

Agneberg, Nils O.....531 1st St., Menominee
Anderson, N. O. (A).....407 Michigan Ave., Berrien Springs
Brukardt, Herman R.....534 First St., Menominee
Dewane, Francis J.....413 10th Ave., Menominee
Glickman, L. Grant.....958 First St., Menominee
Gonty, Arthur.....St. Joseph Lloyd Hosp., Menominee
Heidenreich, John R.....Daggett
Hopson, George H.....104 Tenth Ave., Menominee
Hopson, Patricia C.....104 Tenth Ave., Menominee
Jones, Wm. S.....1146 Tenth Ave., Menominee
Jones, Wm. S., Jr.....1146 Tenth Ave., Menominee
Kerwell, Karm C. (L).....P. O. Box 17, Stephenson
Olson, Robt. C.....828 Tenth Ave., Menominee
Rogers, Raymond J.....205 1st St., Menominee
Towey, John W. (L).....1717 Orchid Lane, Middleton, Wisc.

MIDLAND COUNTY MEDICAL SOCIETY (154)

Athay, R. M. (R).....4622 Concord Ct., Midland
Ballmer, Robt. S.....2715 Ashman St., Midland
Benjamin, Mac B.....4615 Eastman, Midland
Bernier, Jos. A.....218 E. Railway, Sanford
Blackhurst, J. F.....2715 Ashman St., Midland
Blackhurst, Robt. T.....Blackhurst Bldg., Midland
Bowsher, Robt. E.....2719 Ashman St., Midland
Bridge, Robt. G.....2715 Ashman, Midland
Bulmer, Dan J.....116 Harold St., Midland
Bush, Raymond C.....2510 Lucky St., Midland
Buskirk, Maurice D.....110 W. Sugnet, Midland
Cline, J. Daniel.....504 Linwood Dr., Midland
Devlin, James A.....115 Jerome, Midland
Ellis, Ruth.....2510 Ashman, Midland
Fields, Dozier N., Jr.....515 W. Main St., Midland
Gay, Harold H.....Dow Chemical Co., Midland
Goethe, Roy M.....110 W. Sugnet, Midland
Gordon, Harold L.....Dow Chemical Co., Midland
Grant, Robert.....116 Harold St., Midland
Grewe, Norman C.....501 E. Pine St., Midland
Haberstroh, Colleen.....907 Eastman Rd., Midland
Harrigan, William E.....2706 Louanna, Midland
Heffernan, D. D.....402 Dartmouth, Midland
Holder, Benj. B.....Dow Chem. Co. Med. Dept. Midland
Howe, Irvin M.....110 W. Sugnet, Midland
Howell, Richard H.....2719 Ashman, Midland
Ittner, Martin J.....217 N. Saginaw Rd., Midland
Jardinico, Robert E.....1207 N. Michigan Ave., Saginaw
Kramer, Chas. G.....Box 469 Dow Chemical, Midland
Kremski, John A.....Midland Hospital, Midland
Linsenmann, Karl W.....2604 Manor Dr., Midland
Marks, V. A.....2706 Louanna, Midland
Maynard, Wm. A.....208 N. Fourth, Coleman
Meisel, Edward H., Jr.....Masonic Bldg., Midland
Moench, G. Fredk.....147 Center St., Sanford
O'Hora, Bernard A.....110 W. Sugnet Rd., Midland
Pike, Melvin H.....224 E. Larkin, Midland
Pollock, Robert.....Masonic Bldg., Midland
Poznak, Leonard A.....4005 Orchard Dr., Midland
Randolph, Stephen H.....201 E. Ellsworth St., Midland
Redmon, William B.....115 Jerome, Midland
Schoff, Charles A.....2706 Louanne, Midland
Shriner, John W.....902 E. Ashman, Midland
Stewart, Richard.....Dow Chemical Co., Midland
Thamarus, W. E., Jr.....5801 Highland Dr., Midland
Towsley, Wilbur D.....515 W. Main St., Midland
Ulmer, George.....4005 Orchard, Midland
Westphal, Harry O.....3102 Swede Rd., Midland
Willison, Chas. H.....122 Townsend St., Midland
Yobst, G. James.....2719 Ashman, Midland

MONROE COUNTY MEDICAL SOCIETY (158)

Ames, Florence D.....2 W. Noble Ave., Monroe
Barrett, C. D., Sr.....Court House, Monroe
Blakey, Leonard C.....745 N. Monroe St., Monroe
Bond, Wm. W.....222 N. Monroe, Monroe
Burroughs, J. J.....745 N. Monroe St., Monroe
Cigany, Zoltan B.....Carleton
Clark, Bruce.....8308 Lewis Ave., Temperance
Diehl, George Z.....15463 S. Dixie Hwy., Monroe
Douglas, Dale W.....17 E. First St., Monroe
Dranginis, E. J.....Monroe Hospital, Monroe
Ewing, Robert T.....130 Maple Blvd., Monroe
Flanders, John P.....31 Washington St., Monroe
Frary, Reginald A.....423 E. Elm Ave., Monroe
Freud, John W.....1262 N. Macomb St., Monroe
Hensel, Hilda M.....12 E. 4th St., Monroe
Hnatchuk, Nicholas.....8079 Summerfield, Lambertville
Hunter, Marion A.....35 E. Front St., Monroe
Johnson, A. Esther.....751 N. Monroe St., Monroe
Kelso, S. Newton, Jr.....753 N. Monroe St., Monroe
King, John R.....12 East 4th St., Monroe
Laboe, Edward W.....725 N. Monroe St., Monroe
Lammers, Gerald P.....Ida
Liedel, Warren J.....725 N. Monroe St., Monroe
Loan, G. B.....429 N. Monroe St., Monroe
Long, Edgar C.....1310 N. Macomb St., Monroe
McGeoch, Reginald W.....718 N. Macomb St., Monroe
McMillin, John H.....423 E. Elm St., Monroe
Meier, Walter A.....106 East Front St., Monroe
Middleton, W. S.....219 W. Front St., Monroe
Pinkus, Hermann K. B.....12 E. 4th St., Monroe
Reisig, Albert H.....1 S. Monroe St., Monroe
Sisman, Bernard.....749 N. Monroe St., Monroe
Stephenson, Joy O.....15463 S. Monroe St., Monroe
Streicher, Robt. G.....729 N. Monroe St., Monroe
Tomlinson, Ledyard H.....8702 Main, Newport
Wagar, Spencer H.....31 Washington St., Monroe
Weeks, Vernon L.....326 N. Monroe, Monroe
Wilkins, Rolland W.....757 N. Monroe St., Monroe
Williams, Robt. J.....31 Washington St., Monroe
Wood, Russell J.....284 Tecumseh St., Dundee

MUSKEGON COUNTY MEDICAL SOCIETY (162)

Allen, Richard T.....768 W. Broadway, Muskegon Heights
Alt, William J.....Medical Arts Center, Muskegon
Armento, Donald F.....Hackley Union Bk. Bldg., Muskegon
Askam, Ralph F.....Medical Arts Center, Muskegon
Atkinson, Annie L.....1019 Green Creek Rd., North Muskegon
August, Ralph V.....72 E. Broadway, Muskegon Heights
Barnard, Helen S.....33 Diana, Muskegon
Barnes, James W.....102 Professional Bldg., Montague
Barnett, James M.....2416 Peck St., Muskegon Heights
Benedict, Arthur L., Jr.....22 W. Southern Ave., Muskegon
Bloom, Robt. E.....Medical Arts Center, Muskegon
Bolthouse, Robt. E.....2101 Peck St., Muskegon Heights
Bond, Wm. H.....1282 Arthur St., Muskegon
Boyd, De Vere R.....1735 Peck St., Muskegon
Boyd, Jack L.....450 W. Western Ave., Muskegon
Bradshaw, Park S.....Medical Arts Center, Muskegon
Bultema, James H.....Medical Arts Center, Muskegon
Busard, J. Max.....1200 Ransom, Muskegon
Busard, Thos. R.....Medical Arts Center, Muskegon
Carlson, Mr. James C. (A).....2060 Belmont, Muskegon
Chapin, Wm. S. (A).....2136 Sanford, Muskegon Heights
Christophersen, J. W.....1276 Lake Shore Dr., Muskegon
Clapp, Henry W.....88 Strong Ave., Muskegon
Closz, Harold F. (L).....283 W. Western Ave., Muskegon
Clowater, Robert A.....Muskegon Co. San., Muskegon
Cohan, Sol G. (L).....1114 Second St., Muskegon
Cornell, Homer E.....870 N. Second, South Muskegon
Crawford, John W., Jr.....Medical Arts Center, Muskegon
Cronick, Anne B.....435 Whitehall Rd., Muskegon
Dart, Dorothy O.....3956 Whitehall Rd., Muskegon
Dasler, Adolph F.....1507 Peck St., Muskegon
De Leeuw, Henry.....4090 Higate Rd., Muskegon
Diskin, Frank.....1324 Marquette Ave., Muskegon
Dykhuizen, H. D.....289 W. Western Ave., Muskegon
Ellis, Nicholas J.....1891 Lake Shore Dr., Muskegon
Engstrom, Albert D.....126 W. Colby, Whitehall
Farmer, John C.....Medical Arts Center, Muskegon
Fillingham, Enid (R).....1034 Giles Rd., Muskegon
Findorff, William G.....Medical Arts Center, Muskegon
Fleischmann, Chas. B. (L).....250 W. Webster Ave., Muskegon
Fles, Robt. J.....1715 Peck St., Muskegon
Folsom, John D.....1706 Peck St., Muskegon
Frandsen, Philip H.....Medical Arts Center, Muskegon
Fugate, E. M.....Medical Arts Center, Muskegon
Garber, Frank W., Jr.....Hackley Union Bldg., Muskegon
Garber, Frank W.....235 Monroe Avenue, Muskegon
Garrison, Robt. E., Jr.....126 W. Webster Ave., Muskegon
Giese, Douglas H.....204 Mich. Theatre Bldg., Muskegon
Gillard, James L.....1692 Peck St., Muskegon
Goltz, Martha H. (L).....Montague
Gouwens, W. E., Jr.....Medical Arts Center, Muskegon
Griffith, Robt. M.....68 E. Broadway, Muskegon Heights
Hack, Donald W.....Medical Arts Center, Muskegon
Hanley, Wm. J.....315 W. Clay Ave., Muskegon
Harryman, James E.....1200 Ransom St., Muskegon
Hartwell, Shattuck W...450 W. Western Ave., Muskegon
Harvey, John G. Klemm.....Mercy Hospital, Muskegon
Heneveld, Edward H.....1603 Peck St., Muskegon
Heneveld, John (R).....Brasstown, N. C.
Heneveld, Robt. G.....Medical Arts Center, Muskegon
Hennessy, Mary E. (A).....1200 Ransom St., Muskegon
Herald, Osbie J.....1075 Jefferson St., Muskegon
Holly, Leland E.....876 N. Second St., Muskegon
Holly, Leland E., II.....878 N. Second St., Muskegon
Hornbeck, Wm. J.....1200 Ransom St., Muskegon
Huntley, Richard A...1704 W. Sherman Blvd., Muskegon
Jesson, Robt M.....1200 Ransom St., Muskegon
Johnston, E. H.....878 N. Second St., Muskegon
Joistad, Arthur H., Jr.....878 N. Second St., Muskegon
Kane, Thos. J. (M).....2086 Leimert Blvd., Oakland 2, Calif.
Kay, Cecelia S.....932 Second St., Muskegon
Keilin, Marie (L).....307 Liberty Life Bldg., Muskegon
Kerr, Howard J.....3054 Henry St., Muskegon
Kislov, Richard.....Medical Arts Center, Muskegon
Kleaveland, Ingram J.....1670 Peck St., Muskegon
Krenz, Marlin P.....Hackley Union Bk. Bldg., Muskegon
Lange, Eugene W.....337 N. Muskegon Blvd., Muskegon
Lapham, Landon M.....123 W. Colby, Whitehall
Lauretti, Emil J.....Medical Arts Center, Muskegon
Lauretti, L. A.....936 Second St., Muskegon
Laurin, Vilda S. (L).....Medical Arts Center, Muskegon
LeFevre, Geo. L., Jr.....726 Lake Dr., North Muskegon
LeFevre, Wm. M.....315 W. Clay Ave., Muskegon
Lemmen, Lloyd J.....3924 Henry St., Muskegon
Leonard, Mr. A. T. (A).....435 Whitehall Rd., Muskegon
Loder, Leonel L.....289 W. Western Ave., Muskegon
Lowry, Robt. A.....2336 Peck St., Muskegon Heights
Maire, Lewis E.....1633 Peck St., Muskegon
Mandeville, C. B. (L).....815 Hackley Union Bldg., Muskegon
Maples, Douglas E. (A).....Univ. Hosp. Med. Center, Ann Arbor

Marrs, Jack Winton.....Med. Arts Bldg., Muskegon
McNair, John N.....936 Second St., Muskegon
Medema, Paul E.....1017 Sanford St., Muskegon
Meengs, Marvin B.....1725 Peck St., Muskegon
Miller, Phillip L.....1755 Peck St., Muskegon
Mulder, Lambertus.....Medical Arts Center, Muskegon
Mulligan, Alan W. (R)..123 West Larch Ave., Muskegon
Oden, C. L. A. (L).....Medical Arts Center, Muskegon
Parsons, Frank W.....205 Medical Arts Cen., Muskegon
Paterson, Lester C.....1643 Peck St., Muskegon
Peterson, Wm. F.....1094 Jefferson St., Muskegon
Pettinga, Frank L.....1603 Peck St., Muskegon
Prentice, Edwin W.....1017 Sanford St., Muskegon
Risk, Robt. D.....1160 Ransom St., Muskegon
Sanden, Howard V.....1643 Peck St., Muskegon
Scholle, Norbert W.....2500 Peck St., Muskegon Heights
Shebesta, Emil M.....Medical Arts Center, Muskegon
Smith, Robert E.....Medical Arts Center, Muskegon
Steffee, William P.....402 Center St., North Muskegon
Stubbart, F. James.....2416 Peck St., Muskegon Heights
Sweda, George P.....Health Dept. Co. Bldg., Muskegon
Swedenburg, Robt. D...503 Liberty Life Bldg., Muskegon
Swenson, Leland L.....1706 Peck St., Muskegon
Tellman, H. Clay.....302 Med. Arts Center, Muskegon
Thieme, Siegfried W. (L)....12213 Stafford St., Ravenna
Thornton, Eugene S. (L).....301 E. Circle Dr., North Muskegon
Toy, Chas. M.....1067 Pine St., Muskegon
Tyler, Wm. H.....1435 Peck St., Muskegon
Vandervelde, C. A.....283 W. Western Ave., Muskegon
Vangelder, Wm. C.....Medical Arts Center, Muskegon
Voikos, Geo. A.....179 Strong Ave., Muskegon
Wagenaar, Edward H.....3054 Henry St., Muskegon
White, Warren G., Jr.....1624 Peck St., Muskegon
Wiersma, Silas C.....Medical Arts Center, Muskegon
Wildgen, Bernard C.....Medical Arts Center, Muskegon
Wilke, Carl A. (R)....3993 Cemetery Rd., Hillard, Ohio
Williams, Edward V...2501 Baker St., Muskegon Heights
Young, Malcolm C.....1700 Clinton St., Muskegon

NEWAYGO COUNTY MEDICAL SOCIETY (166)

Crowe, Findlay C.....Rt. 1, Hunterbrook Rd., Yorktown Heights, N. Y.
Decker, J. C.....Grant
Deur, Theodore R.....Grant
DeYoung, Jess.....111 W. Dayton, Fremont
Emerick, Robt. W.....Gerber Memorial Hosp., Fremont
Geerlings, Lambert J. (L)....20 N. Division St., Fremont
Klein, J. Paul.....P.O. Box 111, Fremont
Masters, Brooker L.....111 W. Dayton, Fremont
Moore, Hugh R.....Newaygo
O'Neill, John W.....Dist. Health Dept. 5, White Cloud
Painter, Robert.....Grant
Paxton, Robt. E.....40 W. Sheridan, Fremont
Pedelty, Norman.....Newaygo
Vanden Berg, Tunis.....20 N. Division Ave., Fremont
Veenschoten, Girard.....Hesperia

NORTHERN MICHIGAN MEDICAL SOCIETY (170)

Allen, Robt. F.....Lockwood Hospital, Petoskey
Alm, Bernhard T.....418 Petoskey St., Petoskey
Blum, Benj. B.....Burns Clinic, Petoskey
Burns, Dean C.....Burns Clinic, Petoskey
Conkle, Guy C. (L).....Masonic Bldg., Boyne City
Conklin, Frederic L. (A).....Lockwood Gen. Hosp., Petoskey
Connaughton, P. J.....Burns Clinic, Petoskey
Conti, Jos. B.....924 E. Mitchell St., Petoskey
Conway, Wm. S.....Burns Clinic, Petosky
Crippen, Edward F. (A)....USAID, Box KAT, APO 959, San Francisco, Calif.
Drake, Gerald.....511 Waukazoo, Petoskey
Duffie, Don H. (L).....Central Lake
Elliott, Dean C.....Burns Clinic, Petoskey
Foster, Bradford S.....226 Park, Petoskey
Fulmer, Roger C.....Burns Clinic, Petoskey
Grate, Lawrence E.....112 Clinton, Charlevoix
Hegener, Aloysius J.....Burns Clinic, Petoskey
Inyart, Jack R.....Mancelona
Kirk, Thomas R.....Burns Clinic, Petoskey
Knecht, Richard A.....226 Park Ave., Petoskey
Kutcipal, R. A.....Burns Clinic, Petoskey
Larson, Walter E.....456 S. Huron, Cheboygan
Lawrie, Guy K.....6339 Orion Ave., Van Nuys, Calif.
Lentini, Nicholas.....Cheboygan
Litzenburger, A. F.....411 Pearl St., Boyne City
Martin, Robt. G.....707 Bridge, Charlevoix
Mateskon, Victor S.....Burns Clinic, Petoskey
Mayne, Frederick C. (L).....P.O. Box 387, Cheboygan
McCullough, W. L.....Burns Clinic, Petoskey
McEnroe, John E.....Burns Clinic, Petoskey
McKnight, Robt. D.....Burns Clinic, Petoskey
Mertz, Joanne E.....Burns Clinic, Petoskey
Park, Richard.....Burns Clinic, Petoskey
Pearson, Robt. E.....215 Water St., Boyne City
Postle, Jack R.....Burns Clinic, Petoskey
Rauch, Carl T.....420 Riverside Dr., Cheboygan
Reus, Leonard W.....226 Park Ave., Petoskey
Rodger, John R.....Bellaire
Saltonstall, G. B.....112 Clinton St., Charlevoix
Savory, John H.....East Jordan
Schaefer, Joseph C.....Burns Clinic, Petoskey
Smith, James R.....Burns Clinic, Petoskey
Snide, Rollin F.....125 N. Main St., Cheboygan
Spengler, John R.....Burns Clinic, Petoskey
Stringham, James R. (L).....225 Backus St., Cheboygan
Taylor, Robt. M.....Burns Clinic, Petoskey
Van Dellen, Jerrian.....Water St., East Jordan
Webster, Jean H.....200 Sunset St., Petoskey
Weburg, Kathryn D.....Burns Clinic, Petoskey
Zipf, Charles.....Douglas Lake, Pellston

OAKLAND COUNTY MEDICAL SOCIETY (174)

Abbott, Vernon C.....1405 Pontiac St. Bk., Pontiac
Adair, Robin.....800 S. Adams, Birmingham
Adams, Fredk. M.....800 S. Adams, Birmingham
Albert, Donald G.....1665 Twelve Mile Rd., Berkley
Albrecht, Robt. W.....2111 Cass Lake Rd., Keego Harbor
Altshuler, Ira M. (L).....17600 W. 8 Mile, Southfield
Anderson, Alexander S...602 N. Woodward, Birmingham
Arena, Joseph A., Jr...31815 Southfield Rd., Birmingham
Arnkoff, Harry.....45 W. Huron St., Pontiac
Ashare, Raymond.....35 S. Johnson, Pontiac
Aulie, Hal G.....420 Washington Sq. Bldg., Royal Oak
Awes, Lorraine E.....35 S. Johnson, Pontiac
Baier, Kurt.....2186 Garland, Pontiac 19
Baker, Frederick A. (L).....4575 Motorway Dr., Pontiac

Bannow, Robt. J.....880 Woodward Ave., Pontiac
Barker, Chas. P.....214 Wabeek Bldg., Birmingham
Barker, Howard B.....880 Woodward Ave., Pontiac
Barnes, Donald J...717 W. Ten Mile Rd., Pleasant Ridge
Barr, Norman L.....965 Orchard Ridge Rd., Bloomfield Hills
Barrett, John L.....800 S. Adams, Birmingham
Barron, Robert A.....4085 Pontiac Trail, Orchard Lake
Bauer, Bruce D.....22643 Stephenson Hwy., Hazel Park
Bauer, Edward G.....101½ N. Saginaw, Pontiac
Bauer, Ernest W., Sr.....22643 Stephenson Hwy., Hazel Park
Bauer, Ernest W., Jr.....22643 Stephenson Hwy., Hazel Park
Bauer, Franz.....909 Woodward Ave., Pontiac
Baylis, Shelby M.....35 S. Johnson, Pontiac
Beattie, Willard G. (R).....314 W. Maplehurst, Ferndale
Beck, Otto O.....308 Wabeek Bldg., Birmingham
Becker, Paul M.....1890 Southfield Rd., Birmingham
Belknap, Warren F.....1809 S. Main St., Pleasant Ridge
Berg, Richard M.....880 Woodward Ave., Pontiac
Berger, Chas. J.....17220 W. Eight Mile Rd., Southfield
Berman, Bernard D.....1070 N. Telegraph Rd., Pontiac
Berkman, Ruth.....31555 W. Ten Mile Rd., Farmington
Beuker, John T.....1100 N. Woodward Ave., Birmingham
Beyer, Hans A.....5675 Kolly Rd., Birmingham
Birkelo, Carl H.....4680 Dixie Hwy., Drayton Plains
Blackwell, Leonard H. (A)
Blakeney, James R.....17 Utica Rd., Pontiac 11
Blue, Jane.....19125 Hillcrest, Birmingham
Boesky, Malcolm D.....26789 Woodward Ave., Huntington Woods
Boileau, Thornton I.....2075 E. 14 Mile Rd., Birmingham
Bookmyer, Robt M.....31815 Southfield Rd., Birmingham
Boucher, Roman E...4200 N. Woodward Ave., Royal Oak
Bowers, Chas. L.....909 Woodward Ave., Pontiac
Brady, Neal C.....19040 Riverside Dr., Birmingham
Bronson, Wm. W.....28119 John R St., Madison Heights
Brown, Arnold L.....35 S. Johnson, Pontiac
Bryant, F. W.....201 Washington Sq. Bldg., Royal Oak
Budd, Alexander S. Z.....3511 Lakecrest Dr., Birmingham
Buehrig, Robert.....5790 M 15, Clarkston
Bullard, R. W., Jr.....5790 M 15, Clarkston
Burger, John H.....31815 Southfield Rd., Birmingham
Burgess, Bruno.....29250 Longview St., Warren
Burke, Chauncey G.....35 W. Huron St., Pontiac
Butler, Saml. A. (L).....Pontiac State Hosp., Pontiac
Byberg, Robt. A.....420 Washington Sq. Bldg., Royal Oak
Bylsma, Glenn Wm.....Pontiac General Hosp., Pontiac
Cabrera, G. P.....420 Washington Sq. Bldg., Royal Oak
Calhoun, Ethel T.....707 Lakeview Ave., Birmingham
Calkins, Edwin A. (A).....Kendu Mission Hosp., P. O. Kendu Bay, Kenya, East Africa
Campbell, K. N.....1465 Cedar Bend Dr., Bloomfield Hills
Campbell, Malcolm D.....216 Wash. Sq. Bldg., Royal Oak
Capetanakis, D.....3613 Devonshire, Detroit 24
Carlisle, Jos. D.....1810 Woodward Ave., Birmingham
Carpenter, G. B., Jr.....622 N. Woodward, Birmingham
Carrow, Joyce M. (A).....3355 Barlyn Lane, Bloomfield Hills
Cefai, Anthony F.....35 S. Johnson, Pontiac
Chandler, Douglas.....1890 Southfield Rd., Birmingham
Chandler, Jos. H.....1401 S. Washington, Royal Oak
Cheng, James T.....7350 Cooley Lake Rd., Union Lake
Cherup, Nicholas.....Pontiac General Hosp., Pontiac
Childers, Merle A.....320 Walnut, Rochester
Christensen, Willis L.....109 W. Eleven Mile Rd., Royal Oak
Clarke, Harriet A.....130 Seminole, Pontiac
Cline, Alan L.....4299 Roseberry, Drayton Plains
Cobb, Thos. H.....880 Woodward Ave., Pontiac
Cohen, Jack J.....17226 Adrian Rd., Southfield
Cohen, Lewis.....26602 Dundee Rd., Huntington Woods
Collins, Edward F., Jr.....35 W. Huron St., Pontiac
Collon, David, D.D.S. (A).....Romeo
Condon, Frank J.....2401 E. Fourth, Royal Oak
Conner, Edward D.....3856 S. Miller Way, Birmingham
Conrad, Cecil D.....3027 N. Woodward Ave., Royal Oak
Cooksey, Norton J.....801 S. Adams Rd., Birmingham
Cooley, Roy V.....318 S. Blvd. West, Pontiac
Cooper, Edmund L.....4200 N. Woodward Ave., Royal Oak
Cooper, Robt. J. (A).....5917 E. 4th St., Tucson, Ariz.
Cooper, Robt. S.....3027 N. Woodward Ave., Royal Oak
Corrigan, K. E., Ph.D. (A).....Wm. Beaumont Hospital, Royal Oak
Coskey, Ralph J.....22100 Coolidge, Oak Park
Coucke, Henry O.....1148 S. Woodward Ave., Royal Oak
Crissman, Howell C...22750 Woodward Ave., Ferndale 20
Crum, Roger E.....35 S. Johnson, Pontiac
Cudney, Ethan B.....35 S. Johnson, Pontiac
Cutler, Wm. M.....800 S. Adams Rd., Birmingham
Dahlgren, Carl W.....3023 Orchard Lake, Keego Harbor
Darling, C. G., Jr.....880 Woodward Ave., Pontiac
Darmstaetter, A. A., Jr.....227 Briggs Bldg., Birmingham
Dayton, Richard C.....427 W. University Dr., Rochester
Deighton, Murray N.....23023 Orchard Lake Rd., Farmington
De Jongh, Edwin.....Pontiac Motor Div. GMC, Pontiac
Delaney, Malcolm J.....23023 Orchard Lake Rd., Farmington
De Lawter, Hilbert H.....925 E. Maple Rd., Birmingham
Delevie, Jaap B.....640 Riker Bldg., Pontiac
Deutsch, Wm. L.....600 W. 11 Mile Rd., Royal Oak
De Vito, H. Louis.....3052 Sashabaw, Drayton Plains
Dobski, Edwin J.....909 Woodward Ave., Pontiac
Doerr, Louis E., Jr.....1413 S. Washington, Royal Oak
Donnelly, Wm. J.....2561 Elizabeth Lake Rd., Pontiac
Dorsey, John M., Jr...31815 Southfield Rd., Birmingham
Drew, Dale R.....909 Woodward Ave., Pontiac
Duane, William O.....29081 Dequindre Ave., Madison Heights
Dunlap, Gregg L.....2870 Orchard Lake Rd., Keego Harbor
Dunn, Lewis E.....3924 Twelve Mile Rd., Berkeley
Durak, Gerald G.....1809 S. Main St., Pleasant Ridge
Durocher, Normand E.....35 S. Johnson, Pontiac
Dustin, Robt. W.....1314 W. Lincoln, Birmingham
Ekelund, Clifford T. (L).....35 W. Huron St., Pontiac
Elder, Edward E., Jr.....1116 Voorheis, Pontiac
Endress, Z. F., Jr.....35 S. Johnson, Pontiac
Engel, John B. (R).....235 Linden Rd., Birmingham
Ensroth, Jack F.....1100 N. Woodward, Birmingham
Ervanian, Alexander....4321 Meadow Lane, Birmingham
Esslinger, John O...622 N. Woodward Ave., Birmingham
Evseeff, Geo. S.....2685 Amberly Rd., Birmingham
Farah, Jalil.....4385 Shenandoah, Allen Park
Farnham, Lucius A. (L).....622 Riker Bldg., Pontiac
Fink, L. Jerome.....500 W. Huron St., Pontiac
Fishman, Gordon R. A.....25721 Collidge, Oak Park 37
Fitzpatrick, F. J.....92 Spokane Dr., Pontiac
Flaharty, Wm. J.....25000 W. Ten Mile Rd., Southfield
Flick, John R.....120 W. Second St., Royal Oak
Forest, Jean L.....6549 Vernmoor, Troy
Fox, Ralph M.....855 Ridgewood Rd., Bloomfield Hills
Furlong, Harold A.....35 S. Johnson Ave., Pontiac
Fushman, John A.....4200 N. Woodward Ave., Royal Oak
Gaba, Howard B.....17328 Ohio, Detroit 21
Gaber, Ben.....10831 W. Ten Mile Rd., Oak Park 37
Gadbaw, Jos. J.....23607 Farmington Rd., Farmington
Gaensbauer, F.....1965 N. Hammond Lake Dr., Pontiac
Gagliardi, R. A.....880 Woodward Ave., Pontiac
Galpin, Richard R.....525 Southfield Rd., Birmingham
Garber, Max J.....23023 Orchard Lake Rd., Farmington
Gariepy, Bernard F.....120 W. 11 Mile Rd., Royal Oak
Gates, Edward M.....35 S. Johnson, Pontiac
Gates, Joann M.....861 W. Huron St., Pontiac
Gatley, Cleo R. (R).....97 N. Perry St., Pontiac
Gatley, Leslie W.....97 N. Perry St., Pontiac 14
Gehringer, Norman F.....880 Woodward, Pontiac
Geist, Edgar J., Jr.....1500 Walton Blvd., Rochester
Gell, James W.....35 S. Johnson Ave., Pontiac
Gelstein, Lazaro.....909 Woodward Ave., Pontiac
Gerls, Frank B. (L).....602 Pontiac Bank Bldg., Pontiac

Gibson, Wellington C. ... 216 E. Commerce, Milford
Gill, Matthew J. ... 3115 Franklin Rd., Bloomfield Hills
Glen, Harold ... 26559 Grand River, Detroit 40
Goerner, Dorothy M. (A) ... 1500 Henrietta, Birmingham
Goldstein, Herbert ... 22100 Coolidge Hwy., Oak Park 37
Goode, Norman J., Jr. ... 1117 S. Washington Ave., Royal Oak
Gordon, Clayton H. 1009 N. Cranbrook Rd., Birmingham
Gradolph, Paul L. ... 23358 Woodward Ave., Ferndale 20
Gray, Murray H. ... 22100 Coolidge, Oak Park 37
Green, J. Donald ... 217 Briggs Bldg., Birmingham
Green, Ralph S. ... 24100 Stratford, Oak Park 37
Green, Willard M. ... 35 S. Johnson, Pontiac
Grekin, Thos. D. ... 603 W. Eleven Mile Rd., Royal Oak
Gustafson, Everette ... 35 S. Johnson, Pontiac
Gutterman, Meyer A. ... 25085 Coolidge Hwy., Oak Park 37

Haanes, Merle A. ... 909 Woodward Ave., Pontiac
Hackett, Danl. J. ... 782 Owego Dr., Pontiac
Hagman, George L. (L) ... 711 Rogue Valley Manor, Medford, Ore.
Hague, Gilbert W. ... 739 Westview Rd., Bloomfield Hills
Halsted, Lee H. ... 32440 Grand River Ave., Farmington
Hambalgo, George J. ... 3210 Belle Court, Royal Oak
Hammonds, Everett E. (A) ... 304 Barden Rd., Bloomfield Hills
Han, Maolin ... 3358 Auburn Rd., Auburn Heights
Harmon, Lewis G. ... 1775 E. 14 Mile Rd., Birmingham
Harrold, John A. ... 534 Franklin Rd., Pontiac
Harvey, Campbell (L) ... 35 W. Huron St., Pontiac 15
Hassberger, John B. ... 620 N. Woodward Ave., Birmingham
Hathaway, Wm. S. ... 433½ Main St., Rochester
Hayden, H. S., Ph.D. (A) ... Wm. Beaumont Hospital, Royal Oak
Henderson, James E. ... 765 Oakleigh Dr., Bloomfield Hills
Henderson, Worth W. ... 1307 S. Washington, Royal Oak
Hendren, Owen S. ... 1408 Pontiac Bank Bldg., Pontiac 14
Henry, Colonel R. ... 125 W. Nine Mile Rd., Ferndale
Hensley, Chas. B. ... 248 S. Broadway, Lake Orion
Hershey, Lynn N. ... 1100 N. Woodward, Birmingham
Hoekman, Aben ... 1740 Hamilton Dr., Rt. 3, Pontiac
Hopkins, Melvin, Jr. ... 900 Baldwin Ave., Pontiac 11
Hopkins, Wm J. ... 17000 W. Eight Mile Rd., Southfield
Hrushka, Myroslaw ... Pontiac State Hosp., Pontiac
Hsu, John J. ... Pontiac State Hosp., Pontiac
Hubert, John R. ... 880 Woodward Ave., Pontiac 14

Ignatius, Aram A. ... 1915 E. Nine Mile Rd., Ferndale 20
Imperi, Lillian L. ... 13128 Wales, Huntington Woods

Jacobi, Rodman C. ... 91 S. Washington, Oxford
James, Robt. E., Jr. ... 2561 Elizabeth Lake Rd., Pontiac
Jenkins, Henry L. ... 161 State St., Pontiac
Johnson, Clare G. ... 909 S. Woodward Ave., Pontiac
Johnson, J. Frederic ... 23760 N. Woodward, Pleasant Ridge
Jury, Donald B. ... 1126 S. Woodward Ave., Royal Oak

Katz, Sidney F. ... 17350 Dorset, Southfield
Kaufman, Jacob M. ... 26075 Woodward Ave., Huntington Woods
Kay, Sherman A. ... 1026 S. Washington, Royal Oak
Kazdan, Louis L. ... 13801 W. Nine Mile Rd., Oak Park 37
Keeffe, Eugene J. ... 880 Woodward Ave., Pontiac
Kemp, Felix J. ... 880 Woodward Ave., Pontiac
Kendrick, H. F., Jr. ... 35 S. Johnson, Pontiac
Kennison, Warren S. ... 250 Martin, Birmingham
Kerr, Edwin C. ... 32749 Franklin Rd., Franklin
Ketchum, Jesse ... 26075 Woodward Ave., Huntington Woods
Kettler, Hans J. ... 25160 Edgemont Rd., Southfield
Klegman, Jerome H. ... 17000 W. Eight Mile Rd., Southfield
Klewicki, H. A. ... 22720 Woodward, Ferndale 20
Koehler, Wm. H. ... 4416 Far Hill Dr., Birmingham
Koltonow, Lawrence ... The Haven San., Rochester
Kornmesser, James G. ... 23023 Orchard Lake Rd., Farmington
Kozlow, Clifford S. ... 4274 N. Woodward, Royal Oak
Kozlow, L. Ange ... 4274 N. Woodward, Royal Oak
Kozonis, Michael C. ... 880 Woodward Ave., Pontiac
Krane, Mark ... 125 Alice Ave., Pontiac
Krecke, Charles F. ... 917 S. Reading Rd., Birmingham
Kresge, Bruce A. ... 1500 Walton Blvd., Rochester
Krieger, Norman N. ... 402 Union St., Milford
Krohn, Don R. ... 23023 Orchard Lake Rd., Farmington
Kuhel, Eli H. ... 24764 Southfield Rd., Southfield
Kuhn, Anne C. ... 4203 W. 13 Mile Rd., Royal Oak
Kuhn, Robt. E. ... 4203 W. 13 Mile Rd., Royal Oak
Kurnetz, Ruben ... 10831 W. Ten Mile Rd., Oak Park

LaCore, Ivan A. ... 622 Riker Bldg., Pontiac
Ladd, James E. ... 1100 N. Woodward, Birmingham
Lahti, Paul T. ... 3600 W. 13 Mile Rd., Royal Oak
Lambert, Alvin G. ... 3027 N. Woodward, Royal Oak
Lambie, John S. (L) ... 280 Aspen Rd., Birmingham
Landry, Roy A. ... Clarkston Prof. Center, Clarkston
Larson, Alvin R. ... 880 Woodward Ave., Pontiac
Laux, Philip J., Jr. ... 3027 N. Woodward, Royal Oak
Leach, Chas. A., Jr. ... 525 Southfield Rd., Birmingham
Leahy, Etta Link (R) ... 1616 Wiltshire, Berkley
Leichtman, R. R. ... 5770 Ortonville Rd., Clarkston
Levin, Murray B. ... 35 S. Johnson, Pontiac
Levine, Bernard ... 25835 Parkwood Dr., Huntington Woods
Lewis, Sol M. (L) ... 541 W. Oakridge, Ferndale
Lichtwardt, Harry E. ... 247 N. Hunter Blvd., Birmingham
Lichtwardt, John R. ... 247 N. Hunter Blvd., Birmingham
Lilly, Richard J. ... 6530 Cathedral Dr., Birmingham
Limia, Antonio G. ... 24360 Kenosha, Oak Park 37
Ling, T. W. ... 23607 Farmington Rd., Farmington
Linn, Herman J. ... 3601 W. 13 Mile Rd., Royal Oak
Lockwood, Clement E. (L) ... 212 Washington, Holly
Longyear, Harold W. ... 4045 W. 13 Mile Rd., Royal Oak
Lowery, Anthony J. (R) ... 8030 Flagstaff, Union Lake
Lussos, A. S. ... 2707 Bridle Rd., Bloomfield Hills
Lutes, Byron B. ... 1401 S. Washington Ave., Royal Oak
Lyons, Robt. T. ... 35 S. Johnson, Pontiac

Manz, Howard N. ... 23023 Orchard Lake Rd., Farmington
Marcotte, Oliver J. ... 25000 W. Ten Mile Rd., Southfield
Margrave, Edmund D. (L) ... 306 W. Ten Mile Rd., Royal Oak
Margulis, R. Ralph ... 1100 N. Woodward Ave., Birmingham
Markley, John M. ... 655 Ridge Rd., Bloomfield Hills
Marra, John J. ... 461 W. Huron St., Pontiac
Marsa, Percy S. ... 785 N. Lapeer Rd., Lake Orion
Martin, Francis A. ... 880 Woodward, Pontiac
Mason, Robt. J. ... 618 N. Woodward Ave., Birmingham
Mathes, Chas. J. ... 807 Hazelwood Lane, Martinsville, Va.
Mattson, Theo. M. ... 2075 E. 14 Mile Rd., Birmingham
Mayor, Raymond L. ... 1743 Beverly, Pontiac 19
McCain, French H. ... 628 N. Woodward Ave., Birmingham
McCandliss, D. H. ... 35 S. Johnson, Pontiac
McConkie, James P. ... 2425 W. Lincoln, Birmingham
McElroy, Wm. J., Jr. ... 420 E. Fourth St., Royal Oak
McEvoy, Francis J. ... 1715 Crooks Rd., Royal Oak
McHugh, James M. ... 20905 Greenfield Rd., Southfield
McInerney, Thos. S. ... 2026 Laurome, Royal Oak
McIntyre, Kenneth E. (A) ... 3830 Maule Rd., Pensacola, Fla.
McLaughlin, J. H. ... 604 N. Woodward, Birmingham
McNeill, Howard H. ... 161 State St., Pontiac
McPhee, Edward C. ... 909 Woodward, Pontiac
McWhirter, W. W. ... 1401 S. Washington Ave., Royal Oak
Mehas, Constantine P. ... 3040 Chickering Lane Bloomfield Hills
Meinke, Herman A. ... 817 E. Eight Mile Rd., Hazel Park
Meisner, Harry E. ... 25497 Hereford, Huntington Woods
Mercer, Frank A. (L) ... 3032 Morningview Terr., Birmingham
Mevorah, Barukh L. ... 29081 Dequindre Ave., Madison Heights
Milgrom, Sidney ... 1229 S. Washington St., Royal Oak

Miller, Arthur C.....17988 Buckingham, Birmingham
Miller, Hazen L.....31815 Southfield Rd., Birmingham
Miller, Hubert.....28554 Rivercrest, Southfield
Miller, Irving M.....23023 Orchard Lake Rd., Farmington
Miller, Sidney.....800 S. Adams, Birmingham
Mimura, James T.....31815 Southfield, Birmingham
Moloney, James C...5851 Farmington Rd., Orchard Lake
Monroe, John D. (L)....1070 N. Telegraph Rd., Pontiac
Montgomery, J. C. (L)....25717 Coolidge, Oak Park 37
Morin, Leonard A.....29929 Vernon Dr., Southfield
Mueller, Elmer J.....1775 E. Fourteen Mile, Birmingham
Mumby, Clinton J.....26789 Woodward Ave., Huntington Woods
Munson, Harry L.....MacKenzie Clinic, Walled Lake
Murguz, Atalay M.....1625 E. Fourth St., Royal Oak

Nalbandian, Robt. M...20224 Sunnyside, St. Clair Shores
Nalepa, Eugene J.....880 Woodward Ave., Pontiac
Naz, John F. (A).....2826 Orange Grove, Waterford
Nessel, Jack H.....35 W. Huron St., Pontiac
Netzel, Robert J.....1376 Eason St., Pontiac
Newcomb, Arnold B.....19834 Riverside Dr., Birmingham
Nichamin, Samuel J.....20905 Greenfield Rd., Southfield
Nickerson, Ivey D.....6245 Golfview Dr., Birmingham
Niederluecke, D. C.....35 S. Johnson, Pontiac
Nosanchuk, Jos. I.....35 S. Johnson, Pontiac

O'Donnell, C. H.....23338 Woodward Ave., Ferndale 20
Oliphant, Wm. W.....785 N. Lapeer Rd., Lake Orion
Olsen, Richard E.....900 Woodward Ave., Pontiac
O'Neill, James A.....5790 M 15, Clarkston
Ormond, John K. (L).....909 Woodward Ave., Pontiac
O'Sullivan, Girardin S.....26520 Willowgreen Way, Franklin
Ott, Harold A.....3019 N. Woodward, Royal Oak
Ozdaglar, Mehmet.....1821 Keats, Madison Heights

Palmer, Hayden D.....35 W. Huron St., Pontiac
Patrick, Chas. I.....4721 Dixie Hwy., Drayton Plains
Patterson, J. C.....3600 W. Thirteen Mile, Royal Oak
Pauli, Theodore H.....606 Riker Bldg., Pontiac
Payton, Chas. F.....1719 Crooks Rd., Royal Oak
Pear, Erwin G.....3027 N. Woodward Ave., Royal Oak
Pearce, James F.....306 S. Washington Ave., Royal Oak
Pelletier, Chas. J.....1111 N. Campbell, Royal Oak
Pensavecchia, J. S.....3235 Walma Dr., Orchard Lake
Pierce, Wm. H.....800 S. Adams Rd., Birmingham
Piggott, Leonard R.....402 Union St., Milford
Pool, Robert, Jr.....1405 Pilgrim, Birmingham
Porter, Kenneth F.....2709 Bradway Blvd., Birmingham
Ports, Preston W.....33108 Grand River, Farmington
Poznanski, Elva O.....26789 Woodward Ave., Huntington Woods
Poznanski, W. A...1100 N. Woodward Ave., Birmingham
Prather, Frank W.....347 N. Main, Milford
Prevette, Isaac C. (L).....10 W. Huron St., Pontiac 14
Pridmore, John.....2741 Onagon Trail, Pontiac
Proctor, Bruce.....3431 Baldwin, Pontiac

Quarton, Albert E., Jr.....542 Pilgrim Rd., Birmingham
Quinn, James R., Jr.....2070 W. Valley Rd., Bloomfield Hills

Ragins, Abner I.....909 Woodward Ave., Pontiac
Ranney, Kenneth I.....1100 N. Woodward, Birmingham
Raynale, George P. (L)..302 Wabeek Bldg., Birmingham
Read, James A.....610 N. Woodward, Birmingham
Rech, Wm. R.....MacKenzie Clinic, Walled Lake
Reeves, Elizabeth H...7350 Cooley Lake Rd., Union Lake
Reid, Fred T.....49 W. 14 Mile Rd., Clawson
Reid, Robert E.....3228 Belle Court, Royal Oak
Reilly, Richard C.....880 Woodward Ave., Pontiac
Richard, Robert E.....1719 Crooks Rd., Royal Oak
Richards, Wilson P.....201 Creson Bldg., Birmingham
Richardson, Robt. P.....25717 Coolidge, Oak Park 37
Riggs, Harry L.....31 Orchard Lake Ave., Pontiac
Riker, Aaron D.....35 W. Huron St., Pontiac
Roehm, Harold R.....319 Wabeek Bldg., Birmingham
Rowley, Laurie G.....4400 Dixie Hwy., Drayton Plains
Rupp, Edson C., Jr.....1775 E. Fourteen Mile, Birmingham
Rush, Alva D., Jr.....391 Hamilton, Birmingham
Ruskin, David S.....20905 Greenfield Rd., Southfield
Russell, Vincent P.....324 Washington Sq. Bldg., Royal Oak
Rutzky, Julius.....St. Joseph Mercy Hosp., Pontiac
Ruva, Jos. J.....4463 Dixie Hwy., Drayton Plains

Sachau, Rolf K.....Pontiac State Hosp., Pontiac
Sadovsky, Vincent J.....909 Woodward Ave., Pontiac
St. John, Harold A.....35 W. Huron St., Pontiac 15
Salisbury, C. S.....21580 Greenfield, Oak Park 37
Samborski, Anne H.....32316 Grand River, Farmington
Sanford, Glenn A.....35 S. Johnson, Pontiac
Sansone, Thos. J.....909 Woodward Ave., Rochester
Satersmoen, Theodore.....35 S. Johnson, Pontiac
Schaefer, Wm. C.....240 Daines St., Birmingham
Scbirle, Jos. L.....1116 Voorheis Rd., Pontiac
Schlecte, Eve L.....120 Second Ave., Rochester
Schlecte, I. Carl (A).....120 Second Ave., Rochester
Schmitt, Phillip E. (A).....V.A. Hospital, Dearborn
Schoenfeld, Robt. J.....794 N. Woodward Ave., Birmingham
Scholes, Danl. R.....277 Pierce St., Birmingham
Schorling, Otis W.....302 Walnut, Rochester
Schuneman, Howard A.....23760 Woodward Ave., Pleasant Ridge
Schwartz, David.....33120 W. Twelve Mile, Farmington
Schweinsberg, Stephen.....2075 E. Fourteen Mile, Birmingham
Seaborn, Arthur J...1413 S. Washington Ave., Royal Oak
Segula, Robt. L.....35 S. Johnson, Pontiac
Selman, John H.....3306 Auburn Rd., Auburn Heights
Selman, Robert.....500 W. Huron St., Pontiac
Sempere, Chas. R.....35 S. Johnson, Pontiac
Sewell, Geo. R.....411 W. Ten Mile Rd., Pleasant Ridge
Shadley, Maxwell L.....94 Ottawa Dr., Pontiac
Shaptini, Elias A.....Pontiac Mtr. Div. GMC, Pontiac 11
Shea, James Joseph.....35 S. Johnson, Pontiac
Sheffield, Loren C.....35 S. Johnson, Pontiac
Sheridan, F. Michael.....1307 S. Washington St., Royal Oak
Siffring, Loren W.....427 W. University, Rochester
Silvani, John.....909 Woodward Ave., Pontiac
Simpson, David F.....2919 Lakewood, Detroit 15
Simpson, Edward K. (L).....2 Sunset Ave., Chatham, Ont., Canada
Simpson, John R.....800 S. Adams, Birmingham
Smith, Carleton A.....880 Woodward Ave., Pontiac
Smith, Donald S.....1006 Riker Bldg., Pontiac
Smith, Geo. E.....629 Washington Sq. Bldg., Royal Oak
Snyder, Arthur M.....23200 Woodward Ave., Ferndale 20
Somers, Donald C...2338 N. Woodward Ave., Royal Oak
Somerville, Wm. J.....145 Cambridge, Pleasant Ridge
Sosin, Allen.....23023 Farmington Rd., Farmington
Spademan, Loren C.....484 Warren Court, Birmingham
Spencer, Lloyd H...1219 S. Washington Ave., Royal Oak
Spoehr, Eugene L.....22832 Woodward Ave., Ferndale 20
Spohn, Earle W.....201 S. Center St., Royal Oak
Stageman, John C.....909 Woodward, Pontiac
Stanisavljevic, S.....2338 Woodward Ave., Royal Oak
Stanley, Wm. F.....1148 S. Woodward, Royal Oak
Starker, Clarence T. (L).....80 E. Iroquois Rd., Pontiac
Steffes, Everette M.....3345 Coolidge Hwy., Berkley
Stolpman, A. K.....640 N. Woodward, Birmingham
Stratton, Donald P.....3601 W. 13 Mile Rd., Royal Oak
Stremler, Bernard J.....16951 Madoline, Birmingham
Stuecheli, Milton B.....1084 Willow Lane, Birmingham
Sutton, Palmer E.....30153 Bristol Lane, Birmingham 5
Swickle, Edward F.....17 S. Main, Clawson
Swingle, Norman E.....2075 E. 14 Mile Rd., Birmingham
Szappanyos, Bela.....923 S. Glenhurst, Birmingham
Szybko, Valentine.....4274 N. Woodward, Royal Oak

Tarpinian, Dick A.....24601 Coolidge Hwy., Oak Park
Tauber, Abraham.....28 N. Saginaw St., Pontiac
Teshima, John Y.....22720 Woodward Ave., Ferndale 20
Tomboly, Elmer Z.....Pontiac State Hosp., Pontiac
Torgerson, Thos. S.....794 N. Woodward Ave., Birmingham

Touma, Alfred.....26789 Woodward Ave., Huntington Woods
Tregenza, Wm. K.....295 N. Hunter, Birmingham
Trumpour, Donald J.....114 W. University Dr., Rochester
Ulgenalp, Attila O.....880 Woodward Ave., Pontiac
Ulveling, Robert A.....500 W. Huron. Pontiac
Urwiller, K. L.....909 Woodward Ave., Pontiac
Van De Leuv, John H.....91 S. Washington St., Oxford
Vanden Berg, Kenneth.....35 S. Johnson, Pontiac
Van Zoeren, Jay J.....937 Rock Spring Rd., Birmingham
Varbedian, Thos. G.....205 Wabeek Bldg., Birmingham
Vaught, Richard K.....2009 Crooks Rd., Royal Oak
Virga, Geo. M.....715 N. Main St., Royal Oak
Von Valtier, Cheryl C.....202 Walnut Blvd., Rochester
Von Valtier, Wm. F.....202 Walnut Blvd., Rochester
Voss, Erich P.....Pontiac State Hosp., Pontiac
Wagner, Ruth E. (L).....315 Ellen Ave., Royal Oak
Wake, Douglas L.....1406 Woodsboro, Royal Oak
Wallace, Donald B.....880 Woodward Ave., Pontiac
Wangner, William F.....1401 S. Washington, Royal Oak
Ward, W. Paul.....6631 Castle Dr., Birmingham
Warner, Fredk. O.....3245 Sashabaw Rd., Drayton Plains
Watson, Thos. Y.....640 N. Woodward, Birmingham
Weaver, Arthur (A).....91 Depot Line, Karachi, West Pakistan
Webber, Lynn F. (R).....461 Colonial Ct., Grosse Pte. 36
Wegrzyn, George C.....2556 Endsleigh Dr., Birmingham
Weidner, John H.....2075 E. 14 Mile Rd., Birmingham
Wendling, Dieter.....31815 Southfield Rd., Birmingham
Wessels, Robt. R.....302 Wabeek Bldg., Birmingham
Westfall, Edwin J.....1665 Twelve Mile Rd., Berkley
Westmaas, Wm. J.....364 Roanoke St., Birmingham
White, R. Hamilton.....384 Hamilton Ave., Birmingham
Wiant, John L.....258 Briggs Bldg., Birmingham
Wigent, Ralph D.....35 S. Johnson, Suite 26, Pontiac
Wilkinson, Wm. C.....880 Woodward Ave., Pontiac
Williams, John P.....35 S. Johnson, Pontiac
Willis, Maurice E.....35 S. Johnson, Pontiac
Woodward, Robert D.....1100 N. Woodward Ave., Birmingham
Yesko, Veldora C.....26075 Woodward Ave., Huntington Woods
Ylvisaker, John R.....880 Woodward Ave., Pontiac
Young, Arthur R.....35 W. Huron St., Pontiac 15
Zackheim, Herschel S.....13102 Talbot, Huntington Woods
Zimmerman, Walter J...32340 Sylvan Lane, Birmingham
Zinterhofer, J. J., Jr.....27621 Santa Barbara Dr., Lathrup Village
Zujko, Alphonse, J.....880 Woodward, Pontiac

OCEANA COUNTY MEDICAL SOCIETY (178)

Davis, Linford J.....22 N. State St., Hart
Diehl, Clarence E., Jr.....204 N. Mich. Ave., Shelby
Hasty, Willis A.....405 State St., Shelby
Johnson, C. A.....Box 6, New Era
Mullen, Warren R.....Pentwater
Ratzlaff, Alvin J.....219 State St., Hart
Robinson, Wm. G. (A).....Memorial Hospital, Fatehgarh, U. P., India
Vrbanac, John J.....22 N. State St., Hart
Wood, Merle G.....19 Courtland St., Hart

ONTONAGON COUNTY MEDICAL SOCIETY (182)

Archibald, Donald H.....Box 223, Ontonagon
Gordon, E. James.....117 N. Twenty-Second, Escanaba
Hogue, Harold B.....Ewen State Bank Bldg., Ewen
Lahti, Carl R.....800 Zinc St., Ontonagon
Pierpont, John.....White Pine
Strong, James P.....Ontonagon
Strong, Wm. F.....River St., Ontonagon
Vilardo, Ross.....54 Roosevelt Ave., Hasbrouck Heights, N. J.

OTTAWA COUNTY MEDICAL SOCIETY (186)

Arendshorst, Wm.....121 W. 24th St., Holland
Balcer, Edwin A.....1109 Cedar View Dr., Minneapolis, Minn.
Beernink, Ernest H.....408 Fulton St., Grand Haven
Bloemendal, W. B.....224 Washington, Grand Haven
Boersma, Vernon L.....121 W. 24th St., Holland
Bonzelaar, Alvin.....144 W. 26th St., Holland
Boone, Cornelius E. (L).....22 E. Central Ave., Zeeland
Bulthuis, Jerry E.....Jamestown
Chamness, James K.....121 W. 24th St., Holland
Clark, Nelson H.....17 W. 10th St., Holland
Cook, Carl S.....121 W. 24th St., Holland
DeVries, Harold G.....30 E. 9th St., Holland
DeVries, Peter J.....214 Washington, Grand Haven
DeWitt, Donald E.....390 Fairhill Dr., Holland
DeYoung, Fredk. W.....Spring Lake
Dood, Arnold R.....598 Central Ave., Holland
Dykstra, Jerome H.....313 North River Ave., Holland
Endean, Donald H.....121 W. 24th St., Holland
Frieswyk, Melvin J.....241 E. Main St., Zeeland
Groat, Frank L.....631 Franklin St., Grand Haven
Hager, Ralph Hudsonville
Hamelink, Marinus H.....700 W. 26th St., Holland
Harms, Herman P.....17 W. 10th St., Holland
Heard, Wm.....504 Park, Grand Haven
Kearney, Jos. P.....121 W. 24th St., Holland
Kemme, Gerrit J.....Rt. No. 3, Zeeland
Kitchel, John H.....414 Franklin St., Grand Haven
Kitchel, Mary F. S.....414 Franklin St., Grand Haven
Kools, Wm. C.....194 W. 11th St., Holland
Kuipers, Siebe W.....93 E. 29th, Holland
Leppink, R. A.....121 W. 24th St., Holland
Long, Chas. E. (L).....222 Franklin St., Grand Haven
Mahaney, Robert C.....65 W. 22nd St., Holland
McArthur, Peter A.....414 Franklin, Grand Haven
Moerdyk, Wm. J.....120 W. 14th St., Holland
Nykamp, Russel R.....111 E. Main St., Zeeland
Post, J. Jay.....Allendale
Rottschaefer, Wm.....17 W. 10th St., Holland
Rypkema, Willard M.....228 Washington, Grand Haven
Schaftenaar, R. H.....86 E. 28th, Holland
Smit, George J.....Holland
Smit, Henry (A).....c/o Dr. George Smit, 121 W. 24th St., Holland
Stobbelaar, Robt. H.....107 S. Second, Grand Haven
Ten Have, Ralph.....1030 Orchard, Grand Haven
Ten Pas, Henry W.....293 W. 29th St., Holland
Timmerman, Eugene C.....Coopersville
Van Appledorn, C. J.....99 W. 23rd St., Holland
Vander Berg, Edwin E.....17 W. 10th St., Holland
Van Der Velde, Otto.....33 W. 8th St., Holland

Vande Waa, Alfred J.....152 E. Cherry St., Zeeland
Van Kolken, P. J.....509 Franklin Ave., Grand Haven
Veenstra, Bernard M.....Grand Haven
Ver Duin, John W.....223 Washington St., Grand Haven
Verkaik, Peter.....Hudsonville
Wells, Kenneth N.....119 W. Savidge St., Spring Lake
Westrate, Warren K.....17 W. 10th St., Holland
Westrate, Wm., Sr. (L).....17 W. 10th St., Holland
Westrate, Wm., Jr.....17 W. 10th St., Holland
Winter, John K.....726 State St., Holland
Winter, Wm. G., Jr.....630 State St., Holland
Yff, John H.....430 W. Lawrence, Zeeland
Yonkman, Fredk. F.....58 Pomeroy Rd., Madison, N.J.

SAGINAW COUNTY MEDICAL SOCIETY (190)

Ackerman, Gerald L.....124 S. Jefferson Ave., Saginaw
Albers, Millard J.....1227 N. Michigan Ave., Saginaw
Anderson, Wm. K.....845 St. Andrews Rd., Saginaw
App, Robt. G.....520 W. Genesee Ave., Saginaw
Averill, Walter C.....2633 Whitemore Place, Saginaw
Bagley, Ulysses S. (R).....1401½ N. Sixth St., Saginaw
Barry, Jack L.....5670 Dixie Hwy., Saginaw
Bass, Vernon V.....3322 Davenport, Saginaw
Berberovich, Thos. F.....2005 N. Michigan St., Saginaw
Bishop, Harry M.....705 Adams, Saginaw
Bow, William A.....2031 N. Michigan Ave., Saginaw
Brender, Friedrich P.....Frankenmuth
Bruggers, Laurence 1703 N. Michigan Ave., Saginaw
Bucklin, Robt. V.....830 Jefferson Ave., Saginaw
Buechle, George J.....101 Marcy, St. Charles
Bullington, Bert M.....2000 Court St., Saginaw
Burnett, Quinter M.....4385 Concord, Saginaw
Busch, Frank J.....1731 N. Michigan St., Saginaw
Butler, Milton G.....502 S. Jefferson Ave., Saginaw
Cady, Donald J.....2002 Court St., Saginaw
Cady, Fredk. J., Jr.....402 S. Jefferson Ave., Saginaw
Cady, Fredk. J.....402 S. Jefferson Ave., Saginaw
Cameron, Allan K.....1314 S. Jefferson Ave., Saginaw
Campbell, Lloyd A. (R).....335 Brockway Pl., Saginaw
Caumartin, Hugh T...1537 S. Washington Ave., Saginaw
Chisena, Peter R.....6221 Dixie, Bridgeport
Claytor, Archer A.....603 N. 3rd Avenue, Saginaw
Cortopassi, Andre J.....326 S. Washington Ave., Saginaw
Cortopassi, Vital E.....324 S. Washington Ave., Saginaw
Cory, Charles W.....1227 N. Michigan, Saginaw
Cresswell, T. A.....1236 N. Michigan, Saginaw
Cullen, Geo. (A).....2529 N. Clinton St., Saginaw
Curts, James H.....1205 N. Michigan Ave., Saginaw
Davenport, Clyde P.....703 W. Genesee, Saginaw
Derifield, R. S. (A).....25 Bretton Ct., Saginaw
DeYoung, William A.....537 Millard St., Saginaw
Dowidat, Raymond W. (A).....608 Westfield, Saginaw
Durman, Donald C.....408 S. Jefferson Ave., Saginaw
Ely, Cecil W.....1820 Janes Ave., Saginaw
Ernst, Arthur R. (R).....Fieldmont, The Plains, Va.
Farley, Albert W.....1803 N. Michigan Ave., Saginaw
Field, E. Malcolm.....1803 N. Michigan Ave., Saginaw
Fleschner, Thos. E.....Birch Run
Galsterer, Edwin C.....128 S. Jefferson Ave., Saginaw
Gamon, Adam E. II.....2004 Court St., Saginaw
Gardner, Joe H.....815 N. Michigan Ave., Saginaw
Gerard, Roy J.....1500 Gratiot, Saginaw
Gilmore, Robt. D.....234 W. Saginaw, Merrill
Goldner, Richard D.....1024 N. Michigan, Saginaw
Gomon, Louis D.....1203 N. Michigan Ave., Saginaw
Goodsell, John O.....408 S. Jefferson Ave., Saginaw
Goodsell, J. Orton, D.D.S. (A)..1607 Cedar St., Saginaw
Goodwin, J. E.....515 S. Jefferson, Saginaw
Grigg, Arthur P.....320 N. Michigan Ave., Saginaw
Hand, Eugene A.....126 N. Franklin St., Saginaw
Harvie, Lloyd C. (L).....330 S. Washington, Saginaw
Heavenrich, Robt. M.....1107 Gratiot Ave., Saginaw
Heilbronn, Duane B.....1703 N. Michigan, Saginaw
Helmkamp, Herbert O.....333 S. Jefferson, Saginaw
Hereza, Valeriano D.....2125 Bay St., Saginaw
Hester, Eustace G.....2031 N. Michigan Ave., Saginaw
Hill, Victor L. (R).....Box 234, Saginaw
Hubinger, H. L. (A)..501 2nd Natl. Bnk. Bldg., Saginaw
Hyslop, Wm. T.....1610 Gratiot Ave., Saginaw
James, John W.....1021 W. Genesee St., Saginaw
Jarvi, Rudolph M.....1107 Gratiot Ave., Saginaw
Johnstone, Kermit T.....Box 2272, S. Side P.O., Saginaw
Jordan, Leo A.....1524 E. Genesee St., Saginaw
Kerr, Wm. B.....300 S. Michigan St., Saginaw
Keyes, James T.....10222 Maple Rd., Birch Run
Kickham, Edward F.....705 Adams St., Saginaw
Kleekamp, Herbert G.....1005 Gratiot Ave., Saginaw
Kleinschmidt, Earl E.....3625 Webber St., Saginaw
Kolesar, Robt. C.....1005 Gratiot, Saginaw
Kowals, Francis V.....Med. Dir. Chec. Ser. GMC, Saginaw
Kretschmer, Thos. V.....1232 N. Michigan Ave., Saginaw
Lassignal, Jules C.....2125 Bay St., Saginaw
Ling, Kenneth C.....Hemlock
Lohr, Oliver W.....Box 806, Saginaw
Lohr, Thos. O.....1135 N. Michigan Ave., Saginaw
Lonergan, Tad E.....2125 Bay St., Saginaw
Love, Neil W.....505 W. Tuscola, Frankenmuth
Lurie, Robt. I.....2525 S. Washington Ave., Saginaw
Mahaney, Thos. P.....3521 State Street, Saginaw
Manning, John E.....815 N. Michigan Ave., Saginaw
Manning, John W., III.....705 Adams, Saginaw
Markey, Francis L.....808 N. Michigan Ave., Saginaw
Martzowka, Wm. P.....415 W. Genesee St., Saginaw
Mason, Wm. G.....1107 Gratiot Ave., Saginaw
Matthews, Harry C.....1227 N. Michigan Ave., Saginaw
Maurer, John.....1109 Elmdale, Saginaw
Mayne, Harold E.....2111 Marshall Ct., Saginaw
McKinney, A. R. (L).....1403 Howard, Saginaw
Meyer, Henry J. (L).....6243 Dixie Hwy., Bridgeport
Mikan, V. Robert.....3900 Holland Rd., Saginaw
Miller, Glenn F.....2224 Mershon, Saginaw
Moon, A. Raymond (L).....1008 Hancock, Saginaw
Morgrette, Leonard J.....603 S. Jefferson Ave., Saginaw
Mudd, Richard D.....Chev. Grey Foundry, Saginaw
Murphy, Albert P.....303 N. Michigan Ave., Saginaw
Murphy, Richard T., D.D.S. (A).....1718 N. Michigan, Saginaw
Murray, Morris J.....603 S. Jefferson Ave., Saginaw
Nelson, Oscar A.....3324 Davenport, Saginaw
Nelson, Robert E. (A).....1500 Weiss Street, Saginaw
Noble, Paul R.....1447 N. Harrison, Saginaw
Northway, Robt. O.....124 S. Jefferson Ave., Saginaw
Novy, Frank O.....420 S. Jefferson Ave., Saginaw
Olson, Carl P. (A)....122 Morningside Dr., Battle Creek
Phillips, Homer A.....124 S. Jefferson Ave., Saginaw
Pietz, Fredk.....221 N. Michigan Ave., Saginaw
Potvin, Clifford D. (A).....161 Heyn St., Saginaw
Powers, Robt. F.....529 W. Genesee, Saginaw
Prather, Perry E.....1227 N. Mich. Ave., Saginaw
Prinsell, Gustave G. (M).....P.O. Box 33, Sierra Leone, W. Africa
Reimers, Gerald F.....4046 Hess Street, Saginaw
Rice, William T.....1827 N. Michigan Ave., Saginaw
Richards, Ned W.....3518 State St., Saginaw
Richter, Harry J.....705 Adams St., Saginaw
Roggen, Ivan J.....1227 N. Michigan, Saginaw
Roland, C. B.....Univ. of Calif., San Francisco, Calif.
Ruskin, Dave B.....120 N. Michigan Ave., Saginaw
Ryan, Richard S.....1315 S. Washington Ave., Saginaw
Sample, John T. (L).....Box 2254, Saginaw
Sargent, Donald V.....1703 N. Michigan Ave., Saginaw
Schneider, A. J. N.....509 S. Jefferson Ave., Saginaw
Schultz, Frank R.....147 W. Broad St., Chesaning
Sharp, Martin C.....1803 N. Michigan Ave., Saginaw

Shecter, Harry.....330 Brockway Pl., Saginaw
Shek, John L.....808 N. Michigan Ave., Saginaw
Sheldon, Suel A.....124 S. Jefferson, Saginaw
Sherman, John W.....403 S. Fayette, Saginaw
Skowronski, C. A.....1401 E. Genesee St., Saginaw
Slade, Homer G.....1520 N. Michigan Ave., Saginaw
Speer, David L.....451 Westchester, Saginaw
Spengler, Donald E., D.D.S. (A).....4481 Bradford Dr., Saginaw
Stander, Aaron C.....1411 Court St., Saginaw
Stewart, Geo. W.....1902 Janes St., Saginaw
Sulfridge, Hugh L., Jr.....512 N. Michigan Ave., Saginaw
Thompson, Arthur B.....2144 Ottawa St., Saginaw
Tiedke, Gunther E.....120 N. Michigan Ave., Saginaw
Toshach, Clarence E.....3655 Schust Rd., Saginaw
Toteff, Robert J.....2418 Mackinaw, Saginaw
Tramitz, Melvin E.....Saginaw Gen. Hosp., Saginaw
Underhill, Wm. G.....1801 Zauel, Saginaw
Villegas, Alfonso.....304 Park Pl., Charlottesville, Va.
Vincent, John H.....1911 Seminole Lane, Saginaw
Vitu, Robert L.....808 N. Michigan Ave., Saginaw
Volk, Vladimir K...Saginaw Co. Hosp., Box 65, Saginaw
Waite, Barry F.....403 S. Fayette, Saginaw
Webb, Walter L.....1502 Wadsworth, Saginaw
Weiss, Arno W.....3521 State St., Saginaw
Westlund, Norman.....3253 Congress, Saginaw
Woomer, Donald F.....1227 N. Michigan Ave., Saginaw
Wright, Edwin M.....1311 N. Michigan, Saginaw
Yntema, Stuart.....331 S. Jefferson Ave., Saginaw

ST. CLAIR COUNTY MEDICAL SOCIETY (194)

Bailey, Robt. S.....2425 Military St., Port Huron
Banting, Kenneth C...403 Peoples Bk. Bldg., Port Huron
Barss, J. A.....1209 Tenth St., Port Huron
Battley, John C. S.....1216 6th St., Port Huron
Beck, Frank K.....2902 Military St., Port Huron
Beer, Jos. F.....104 N. Riverside Ave., St. Clair
Bennett, Wm. G.....210 S. Main St., Yale
Borden, Chas. L.....313½ Huron Ave., Port Huron
Bottomley, Thos. H., Jr.....1102 Sixth St., Port Huron
Boughner, Walter H.....325 Pleasant St., Algonac
Bovee, Marion E. (L).....2208 Stone St., Port Huron
Bowden, Wm. S.....130 Washington, Marine City
Bridge, Ezra V.....416 Edison Blvd., Port Huron
Brush, Howard O.....3307 Walnut, Port Huron
Burke, Colman J...411 Andrew Murphy Dr., Port Huron
Cantwell, John D., Jr.....2425 Military St., Port Huron
Carrie, Robt. G. (A).....837 Marconi, Montebello, Calif.
Chafty, Mahmoud.....2425 Military St., Port Huron
Cleland, Wm. D., Jr.....Medical Arts Bldg., Port Huron
Clifford, Robt. P.....506 S. Riverside Dr., St. Clair
Clyne, Benj. C.....103 N. Main St., Yale
Cooper, Thos. H. (L).....2435 N. River Rd., St. Clair
Coury, John J., Jr.....1209 Tenth St., Port Huron
Davison, Wm. T.....2425 Military St., Port Huron
Dinnen, Wm. J., Jr. 2425 Military St., Port Huron
Douvas, Nicholas G.....311 Pine St., Port Huron
Dupuis, Jean Paul.....4251 Peck Rd., Port Huron
Fitzgerald, E. W., Jr.....1102 Sixth St., Port Huron
Franke, Armin T.....2425 Military St., Port Huron
Fulton, Harold E., Jr.....2425 Military St., Port Huron
Gerrits, James F.....St. Clair Clinic, St. Clair
Gholz, Anthony C.....Medical Arts Bldg., Port Huron
Gilmore, John R.....317 Mich. Bank Bldg., Port Huron
Gonzalez, Carlos F.....1605 Division Rd., St. Clair
Hazledine, H. J.....4406 Gratiot Ave., Port Huron
Holcomb, Russell J.....140 S. Market, Marine City
Hoyt, Chas. N. (A).....685 Woods Lane, Grosse Pointe Woods
Johnston, Thomas C.....2425 Military St., Port Huron
Kahn, Oscar B.....Capac
Kesl, Geo. M. (L).....316 Sperry Bldg., Port Huron
Kirban, Harry N..... 5500 Lakeshore Rd., Port Huron
Kirker, Findlay O.....1325 Michigan Ave., Marysville
Koch, Donald A.....2425 Military St., Port Huron
Lauridsen, James.....621 River St., Port Huron
LeGalley, K. B.....Awali Bahrain, Persian Gulf
Licker, Reuben R.....2425 Military St., Port Huron
Ludwig, Claude A.....916 Seventh St., Port Huron
Ludwig, Fredk. E.....916 7th St., Port Huron
Lugg, Robt. M.....619 River St., Port Huron
MacPherson, C. A. (R).....401 Country Lane, Louisville, Ky.
Martin, Clyde S. (R).....Whispering Waters, Bldg. D 4, Apt. 2, Winter Park, Fla.
Mayhew, Harry E.....8199 S. Riverside, Marine City
McColl, Duncan J. (L)..917 Prospect Place, Port Huron
Meza, Pedro.....902 Tenth, Port Huron
Miller, John M.....1010 Griswold St., Port Huron
Mohney, Glenn E.....311 Pine St., Port Huron
Morris, Alvin N.....621 River St., Port Huron
Novak, Walter S.....310 E. Water, Port Huron
Patterson, Dorsey W.....622 Huron Ave., Port Huron
Pollock, Donald A. (A).....5014 Lakeshore, Port Huron
Raftery, Michael.....2425 Military St., Port Huron
Rowe, Robt. E.....3360 W. Water St., Port Huron
Sanderson, J. L.....515 Pine St., Port Huron
Sands, Geo. E. (L).....3227 Gratiot Ave., Port Huron
Schaefer, Waldo A.....302 Mich. Bank Bldg., Port Huron
Selby, Clarence D.....1916 Military St., Port Huron
Serniak, John A.....104 S. Main St., Yale
Shoudy, Elmore D.....902 Tenth Ave., Port Huron
Sites, Edgar C.....1209 Tenth St., Port Huron
Tisdel, James H.....310 E. Water St., Port Huron
Tomsu, Glenn F.....310 E. Water St., Port Huron
Townley, Chas. O.....1209 Tenth St., Port Huron
Ulmer, Arthur H., Jr.....1209 Tenth St., Port Huron
Walker, Sidney C.....1209 Tenth St., Port Huron
Ware, J. Raleigh.....3107 24th St., Port Huron
Wass, Henry C.....115 Adams, St. Clair
Weckesser, W. C.....1602 Military St., Port Huron
Wetzel, John O. (R).....700 Intercostal Dr., Ft. Lauderdale, Fla.
Yost, Kenneth W.....1305 Gratiot Ave., Marysville
Youngs, John A.....718 Griswold St., Port Huron

ST. JOSEPH COUNTY MEDICAL SOCIETY (198)

Berg, Lawrence A.....106 E. Chicago Rd., Sturgis
Bradley, D. E.....428 Burr Oak Rd., Colon
Braham, Wilbur G.....111 S. Monroe, Sturgis
Brothers, Paul L.....104 S. Lakeview, Sturgis
Brunson, Allen E.....206 E. West St., Sturgis
Evans, Robt. H.....111 S. Monroe St., Sturgis
Fiegel, S. Albert.....111 S. Monroe, Sturgis
Fortner, Roscoe J.....137 Portage Ave., Three Rivers
Gillespie, Eleanor M.....R. 2, Sturgis
Hill, Robert V.....117 Spring St., Three Rivers
Jacobowitz, John M.....Lincoln at Millard, Three Rivers
Lamb, Harry.....107 John D. Ct., Sturgis
Lepard, Olin L.....Knollwood Dr., R. 1, Sturgis
Miller, Chas. G. (L).....106 W. Chicago St., Sturgis
O'Dell, Charles W.....117 Spring St., Three Rivers
O'Dell, John H., Jr.....117 Spring St., Three Rivers
Olney, Frank Leonidas
Olney, Harold E.....Leonidas
Pennington, Harry C.....118 S. Kalamazoo, White Pigeon

Penzotti, Stanley C......117 Spring St., Three Rivers
Porter, Clark G.....226 East St., Three Rivers
Schimnoski, D. R.....Three Rivers Med. Clnc., Three Rivers
Shaw, Geo. D.....117 Spring St., Three Rivers
Sheldon, John P.....206 E. West St., Sturgis
Smith, Robt. D.....Colon
Springer, Russell A. (R).....R. 2, Sturgis
Storer, William R.....St. Jos. Co. Health Dept., Centerville
Weisheit, H. R.....Route 1, Sturgis
Zimont, Chas. R.....Constantine
Zimont, Raymond D.....Constantine

SANILAC COUNTY MEDICAL SOCIETY (202)

Cripps, James R......Marlette
Duvall, Dorothy V.....817 Patterson Ave., Bay City
Ford, Frances A.....2683 S. Lakeshore Rd., Applegate
Gift, Weldon A.....Marlette
Groat, Gerald Deckerville
Hart, Robt. K.....Croswell
Jayson, Michael H.....2764 Lorraine St., Marlette
McCrea, John W.....Marlette
McGunegle, Keate T.....Sandusky
Muir, Neil.....Croswell
Seager, M. Cole.....Brown City
Smith, Duane E.....Brown City
Tweedie, G. Evans.....Sandusky
Tweedie, S. Martin.....Sandusky
Webster, J. C. (L).....Marlette
Winfield, Raymond J.....3014 Main St., Marlette

SHIAWASSEE COUNTY MEDICAL SOCIETY (206)

Arnold, Alfred L. (L).....R. 1, Ovid
Austin, Eugene S.....1260 Ada St., Owosso
Bach, Norman F.....113 E. Williams, Owosso
Bjarnesen, Walter.....Durand Medical Clinic, Durand
Breedlove, Dane Durand
Brown, Richard C.....113 E. Williams St., Owosso
Brown, Richard J. (R).....9230 Cedar Knoll Dr., Grass Lake
Buzzard, Walter D.....Chesaning
Chipman, Elwood M. (R)..502 W. Williams St., Owosso
Clifford Robert.....Matthews Bldg., Owosso
Ford, Wm. J. A., Jr.....113 E. Williams St., Owosso
Forsyth, Henry T.....Chesaning
Graves, James H.....511 W. Main St., Owosso
Gurden, Elizabeth A. L.....113 E. Williams St., Owosso
Harroun, John E.....105 N. Water St., Owosso
Harroun, R. V.....Matthews Building, Owosso
Hofstra, John Owosso
Hoshal, Verne L.....104 W. Clinton, Durand
Kennedy, John J.....1626 N. Chipman, Owosso
Lieber, Robt. W.....103 E. Clinton St., Durand
MacGregor, John F.....113 E. Williams St., Owosso
McKnight, Edwin R.....320 N. Washington St., Owosso
Merz, Walter L.....307 N. Ball, Owosso
Moore, Phillip J.....221 E. North St., Owosso
Morin, Richard Durand
Park, James H.....812 Bradley St., Owosso
Phillips, Rolland.....Matthews Bldg., Owosso
Richards, Chester J.....213 Mercer, Durand
Sahlmark, Jos. F.....812 Bradley St., Owosso
Sauer, Peter.....113 E. Williams, Owosso
Shepherd, Walter F. (R)..921 Coolidge Rd., Lansing 12
Trick, O. L.....Durand
Weinkauf, Wm. F.....Corunna
Weston, Claude L.....Matthews Bldg., Owosso
Wickstrom, Geo. B.....529 Clark Ave., Owosso

TUSCOLA COUNTY MEDICAL SOCIETY (210)

Anderson, Norma Caro
Ballard, James H.....Cass City
Chapin, Maurice H.....Millington
Cole, Versa V.....Lock Box A, Caro
Dickerson, Willard W.....Caro State Hosp., Caro
Donahoe, Harold T.....Pleasant Home Hosp., Cass City
Elmendorf, E. N., II.....Vassar
Flett, Richard O.....Millington
Gugino, Frank J.....Reese
Howlett, Robt. R.....624 W. Frank St., Caro
Loree, Joseph E.....Caro State Hospital, Caro
Merrill, Elmer H.....147 W. Lincoln St., Caro
Miles, Edward J.....Caro
Nigg, Herbert L.....Caro
Savage, Lloyd L.....147 W. Lincoln, Caro
Swanson, Ewald C.....220 N. Main, Vassar
Von Renner, Otto (L).....837 W. Huron St., Vassar

VAN BUREN COUNTY MEDICAL SOCIETY (214)

Boothby, Carl F.....Hartford
Boothby, Fredk. M.....Lawrence
Boothby, Paul Lawrence
Bope, Wm. P. (L).....Decatur
Cooper, Jos. E.....417 W. Monroe St., Bangor
Davis, James M.....311 Center St., South Haven
Diephuis, Bert.....511 Huron St., South Haven
Dillon, Thos. J.....R.F.D. 3, Paw Paw
Gano, Avison.....417 Monroe St., Bangor
Groustra, Glenn R.....511 Huron St., South Haven
Holm, Leo H.....Gobles
Itzen, John F.....P.O. Box 128, South Haven
Johnson, Harold C. A.....Upjohn Co., 320 Portage, Kalamazoo
Kleber, John A.....311 Center St., South Haven
Korpi, Steven.....M40 North, Decatur
Lawther, John.....P.O. Box 191, Hartford
Loomis, Frank J.....Paw Paw
Millard, David Paw Paw
Morgan, Dale K.....403 Phoenix St., South Haven
Parks, Arthur E.....Lawton
Spalding, R. W.....Box 187, Bloomingdale
Stagg, Adelbert L.....9 N. Maple St., Hartford
Stagg, G. Lee.....Box 307, Hartford
Stagg, Ruth E. A.....Box 38, Hartford
Steele, Arthur H.....Paw Paw
Sundin, Paul W.....Decatur
Ten Houten, Charles.....Paw Paw
Terwilliger, Edwin H.....P.O. Box 110, South Haven
Urist, Martin J.....R.D. 1, South Haven
Young, Wm. R. (L).....Lawton

WASHTENAW COUNTY MEDICAL SOCIETY (218)

Abrams, Gerald D. (M).....2411 Ross Rs., Apt. 102, Silver Springs, Md.
Alford, Barry H.....385 N. Mill, Plymouth
Aliferis, Peter.....211 Sunset Blvd., Alpena
Allen, Arthur W.....5 Harvard Pl., Ann Arbor
Allen, Richard J.....University Hospital, Ann Arbor
Anderson, David G.....627 Westwood, Ann Arbor
Anderson, Jerry W. (A).....1716 Glastonbury Rd., Ann Arbor
Angell, David C. (A)....2603 Pittsfield Blvd., Ann Arbor
Atchison, Russell M.....501 W. Dunlap, Northville

Badgley, Carl E. (L).....1313 E. Ann St., Ann Arbor
Bailey, Robt. W.....University Hosp., Ann Arbor
Baird, Walter M. (A).....2260 Parkwood, Ann Arbor
Bandera, Emily A.....2800 Plymouth Rd., Ann Arbor
Banghart, Norman L...1950 Manchester Rd., Ann Arbor
Barker, Paul S. (R).....Box 87, Bonnots Mill, Mo.
Barlow, Peter P.....31815 Southfield, Birmingham
Barlow, R. Craig.....326 N. Ingalls St., Ann Arbor
Barnwell, John B. (R).....R.F.D. 2, Blairstown, N. J.
Barron, Walter L. (A).....280 Gralake Ave., Ann Arbor
Barss, Wm. A.....525 W. Cross St., Ypsilanti
Bartholomew, Lee E.....4633 Kresge Bldg., U.M., Ann Arbor
Bass, Thos. J.....201 S. Hamilton, Ypsilanti
Bassow, Paul H.....St. Joseph Hosp., Ann Arbor
Bauer, Gerhard H.....2015 Manchester Rd., Ann Arbor
Bauer, Jere M.....1313 E. Ann St., Ann Arbor
Beatty, James B. (M).....85 Red Cloud Rd., Ft. Rucker, Ala.
Beckett, Morley B..... 207 Fletcher Ave., Ann Arbor
Behrman, Saml.....1313 E. Ann St., Ann Arbor
Beierwaltes, Wm. H.....U.M. Medical Center, Ann Arbor
Beljan, John R. (A).....1 USAF Hospital ADC, Selfridge AFB
Bell, Margaret (L)..1719 East Prince Rd., Tucson, Ariz.
Belser, Walter.....2101 Woodside Rd., Ann Arbor
Bender, Leonard F.....1313 E. Ann St., Ann Arbor
Benson, Paul J. (A)..St. Joseph Mercy Hosp., Ann Arbor
Bentley, Fredk. E.....851 S. Main St.. Plymouth
Berkley, Kelly M.....1606 Waltham Dr., Ann Arbor
Berry, Robert E. L.....University Hospital, Ann Arbor
Bicknell, John N.....703 First Natl. Bldg., Ann Arbor
Bicknell, Joseph M. (A).....97 Valhalla Dr., Ann Arbor
Bird, H. Waldo, Jr.....1313 E. Ann St., Ann Arbor
Bishop, Ronald C.....1011 Lincoln Ave., Ann Arbor
Boblitt, Delbert E.....St. Joseph Mercy Hosp., Ann Arbor
Boles, Roger (A).....1224 Bending Rd., Ann Arbor
Bosch, Jan K.....302 W. Main St., Northville
Botch, Edmund S.....115½ E. Liberty St., Ann Arbor
Botsford, James H.....109 N. Main St., Chelsea
Bourne, Charles W. (A).....Univ. Hospital, Ann Arbor
Bourne, Richard B. (A).....Univ. Hospital, Ann Arbor
Brandt, Ralph L.....326 N. Ingalls, Ann Arbor
Breakey, Barry A.....1029 Pine Tree Dr., Ann Arbor
Brewer, Wilson K.....720 E. Catherine St., Ann Arbor
Briere, Russell O. (A)..2816 Brandywine Dr., Ann Arbor
Brody, Gerald L.....1207 Chapel Ct., Ann Arbor
Brown, Philip N.....Northville State Hosp., Northville
Brown, Wm. E., III.....1517 Granger Ave., Ann Arbor
Brownell, Robt. D. (A).....2424 Yost Blvd., Ann Arbor
Bryan, George C.....2547 Ellis Rd., Ypsilanti
Bryant, H. C.....425 E. Washington, Ann Arbor
Buchanan, Robert A.....2715 Brockman, Ann Arbor
Bull, Frances E.....University Hospital, Ann Arbor
Bush, Jack L.....2737 Colony, Ann Arbor
Butler, Gerald E.....5 Dover Ct., Ann Arbor

Cabrera, Jorge A. (A).....Laprida, 318 San Isidro, Prov. De BS AS, Argentina
Cameron, Hugh A.....425 E. Washington St., Ann Arbor
Campbell, Darrell A.....617 Stratford, Ann Arbor
Carbeck, Robt. B.....2315 Walter Drive, Ann Arbor
Carr, Edward A., Jr.....Dept. of Pharm. U. of M., Ann Arbor
Carroll, Catherine.....1130 Hill St., Ann Arbor
Carron, Dean P.....425 E. Washington, Ann Arbor
Cassidy, James T. (A).....618 Westwood, Ann Arbor
Cerny, Joseph C. (A)..University Med. Ctr., Ann Arbor
Cheris, David N. (M).....Base Hospital, MacDill AFB, Tampa, Fla.
Child, Chas. G., III.....University Hospital, Ann Arbor
Christopher, Robt. P. (A)..University Hosp., Ann Arbor
Clifford, Mary Ellen.....University Hospital, Ann Arbor
Clyde, Ensign E.....1246 Sheridan Ave., Plymouth
Cohan, Bruce E. (A).....University Hospital, Ann Arbor
Coller, Fredk. A. (L).....St. Josephs Mercy Hosp., Ann Arbor
Conn, Jerome W.....200 Orchard Hill Dr., Ann Arbor
Corssen, Gunter.....3490 Miller Rd., Ann Arbor
Crook, Clarence E.....2112 Wallingford, Ann Arbor
Cross, Thomas N.....Univ. Medical Center, Ann Arbor
Culver, Raymond E. (A).....1140 Heather Way, Ann Arbor
Cummings, Howard H. (L).....326 N. Ingalls St., Ann Arbor
Curtis, Arthur C.....1313 E. Ann St., Ann Arbor
Curtis, Edward G.....1825 W. Stadium Blvd., Ann Arbor

Davenport, Fred M.....1038 Martin Pl., Ann Arbor
Davey, Winthrop N.....1405 E. Ann St., Ann Arbor
Davis, James H.....502 Rosemont, Saline
Deatrick, Richard W.....2940 Hickory Lane, Ann Arbor
DeJong, Russell N.....1313 E. Ann St., Ann Arbor
DeJong, Bud R.....715 Plum St., Ann Arbor
Demuth, George R.....Univ. Hospital, Ann Arbor
Den Houter, W. D.....1005 W. Ann Arbor Tr., Plymouth
DeTar, John S.....55 W. Main St., Milan
DeWeese, Marion S.....University Hospital, Ann Arbor
Dieterich, Gordon C.....820 E. University, Ann Arbor
Dillman, Richard S.....1800 Baldwin, Ann Arbor
Dingman, Reed O.....1029 Chestnut Rd., Ann Arbor
Dodson, Vernon N.....1638 University Hosp., Ann Arbor
Dolfin, Wilbur E.....2210 Melrose, Ann Arbor
Domino, Edward F.....1325 Brooklyn, Ann Arbor
Douthat, Rudenz T.....213 S. Ann Arbor St., Saline
Dryer, Clyde K.....3033 Sophia St., Wayne
Dukay, Alexander P.....Ypsilanti State Hosp., Ypsilanti

Earle, Richard H. (M).....2119 Agin Ct., Ann Arbor
Edmunds, Wm. P.....21 S. Prospect, Ypsilanti
Eliot, Johan W.....Sch. of Pub. Health, Ann Arbor
Elliott, Lyle D.....26 S. Prospect, Ypsilanti
Engelke, Otto K...313 Washtenaw Co. Bldg., Ann Arbor
Entwistle, F. R. (A)....2851 Canterbury Rd., Ann Arbor
Ericeson, Judith A.....703 Berkshire, Ann Arbor
Ericsson, Arthur D.....Univ. Medical Center, Ann Arbor
Evans, Tommy N.....1001 Belmont Rd., Ann Arbor

Fajans, Stefan S.....248 Devonshire, Ann Arbor
Falk, Elwin C.....Ford Mtr. Co., Box 412, Ypsilanti
Falls, Harold F..... University Hosp., Ann Arbor
Fayos, Juan V.....University Med. Center, Ann Arbor
Feller, Irving.....2565 Carmel St., Ann Arbor
Fellman, S. L.....2216 Medford Rd., Ann Arbor
Ferrington, R. A.....519 W. Main St., Milan
Finch, Stuart M.....Child Psychiatric Hosp., Ann Arbor
Finger, John E. (A).....Dept. of Path. Bas. Sci. B., Ldg. U.M., Ann Arbor
Fink, Geo. C.....411 N. Ingalls St., Ann Arbor
Fischmann, George.....1321 Franklin Blvd., Ann Arbor
Fisher, Jos. V.....Chelsea
Fox, Winslow G.....715 N. University, Ann Arbor
Fralick, F. Bruce.....University Hospital, Ann Arbor
Francis, Thos., Jr.....U. Mich. Schl. Pub. Hlth., Ann Arbor
Fransway, Robt. L.....Parke Davis and Co., Ann Arbor
French, A. James.....1313 E. Ann St., Ann Arbor
Fries, Gene T. (A).....3070 Golfide Dr., Ypsilanti
Frohlich, Moses M.....1313 E. Ann St., Ann Arbor
Frost, Lyle W.....309 N. Washington St., Ypsilanti
Frye, Carl H.....301 N. Ingalls St., Ann Arbor

Furstenberg, A. C. (L).....1313 E. Ann St., Ann Arbor
Gabrielsen, T. O. (A).....2341 Darrow Dr., Ann Arbor
Gerigk, Paul F.....205 S. Davenport, Saline
Getting, Vlado A.....1200 Arlington Blvd., Ann Arbor
Gignac, Ralph M.....32320 Michigan, Wayne
Gikas, Paul W.....V.A. Hospital, Ann Arbor
Giles, Conrad L. (M).....Dept. of Hlth. Edu. & Welf., Bethesda 14, Md.
Ging, Rosalie J.....Veterans Adm. Hosp., Ann Arbor
Goldsmith Robt. I.....1708 Shadford Rd., Ann Arbor
Gosling, J. R. G.....6 Buckingham Ct., Ann Arbor
Gotz, Alexander.....2201 Medford Rd., Ann Arbor
Gough, Joseph G. (A).....3423 Edgewood, Ann Arbor
Gould, Stuart M., Jr.....Mercywood Hosp., Box 65, Ann Arbor
Grabb, William C.....221 N. Ingalls St., Ann Arbor
Gracie, Wm. A., Jr.....University Hospital, Ann Arbor
Graves Wm. H., III.....1 Medford Circle Ann Arbor
Grawn, Frank A. (R).....604 Pearl St., Ypsilanti
Gray, J. McNicoll (A).....1119 Maiden Lane Ct., Ann Arbor
Greene, James A., Jr. (A).....2507 Geddes Ave., Ann Arbor
Grillo, S. Phillip.....265 Main St., Belleville
Groves, Fred B. (A).....602 Brierwood Ct., Ann Arbor

Hagerman, Geo. W.....321 N. Ingalls St., Ann Arbor
Haight, Cameron.....1313 E. Ann St., Ann Arbor
Hammond, Walter W., Jr.....905 W. Ann Arbor Trail, Plymouth
Handorf, Heinrich H.....Penniman Allen Theatre, Northville
Hankamp, Lamar J.....2119 Woodside, Ann Arbor
Hannum, Marvin R.....54 W. Main, Milan
Hanson, Frederick N.....45341 Harmony Lane, Belleville
Harrell, E. R., Jr.....1313 E. Ann St., Ann Arbor
Harris, Bradley M.....27 S. Prospect, Ypsilanti
Harris, Scott T.....1144 Roosevelt Blvd., Ypsilanti
Harrison, Saul I.....Child Psychiatric Hosp., Ann Arbor
Hartman, Robt. T.....519 W. Main, Milan
Heetderks, D. R., Jr. (A).....Saudid Base Hosp., Saudid Base Hosp., Albuquerque, N. M.
Henderson, John W.....University Hosp., Ann Arbor
Hendrix. Robt. C.....1139 Vesper Rd., Ann Arbor
Henry, L. Dell.....706 W. Huron St., Ann Arbor
Hicks, Samuel P.....1112 Meadowbrook, Ann Arbor
Hildebrandt, H. Mark.....1130 Hill St., Ann Arbor
Himler, Leonard E.....1225 Fairoaks Pkwy., Ann Arbor
Hinerman, Dorin L.....1313 E. Ann St., Ann Arbor
Hing, Ng Harry.....St. Joseph Mercy Hosp., Ann Arbor
Hiraga, Mikio H.....2433 Colony Ct., Ann Arbor
Hoag, Robert D. (A).....1106 Norman Place, Ann Arbor
Hodges, Fred J.....1313 E. Ann St., Ann Arbor
Holmes, Donald J.....505 Barton North Dr., Ann Arbor
Holmes, Joyce M.....591 Montgomery St., Jersey City, N.J.
Holt, John F.....1313 E. Ann St., Ann Arbor
Holtz, Fred.....326 N. Ingalls, Ann Arbor
House, Frederic B.....1240 Crosby Crescent, Ann Arbor
Howard, Stacy C. (R).....Rt. 3, Hendersonville, N.C.
Howard, W. Leonard.....Maybury San., Northville
Howatt, William F.....University Hospital, Ann Arbor
Hubbard, Wm. N., Jr.....Univ. of Mich. Med. Sch., Ann Arbor
Huizenga, Philip B. (A).....Box A, Ypsilanti
Hulett, Ralph M.....1444 Glastonbury Rd., Ann Arbor
Hyman, Saml. J.....27342 Michigan Ave., Inkster

Ideson, Robt. S., II.....200 N. Ingalls St., Ann Arbor
Iizuka, Reiichi.....49 Davis Drive, Saginaw

Jacob, Jos. S.....202 E. Washington St., Ann Arbor
Jacobs, David S. (A).....5616 W. 92nd St., Shawnee Mission, Kansas
Jeffries, Frank W.....1614 Arbordale, Ann Arbor
Jimenez, B. (R).....215A S. Main St., Ann Arbor
Johnson, David A.....489 Blunk, Plymouth
Johnson, Robt. D.....3432 Woodlea Dr., Ann Arbor
Johnston, Franklin D.....1313 E. Ann St., Ann Arbor
Johnston, Robert F. (A).....1608 Brooklyn, Ann Arbor
Jones, Elizabeth.....2121 Highland Rd., Ann Arbor
Judge, Richard D.....Univ. Medical Center, Ann Arbor
Julian, Mark D.....740 S. Emerick, Ypsilanti

Kabza, Theodore G.....326 N. Ingalls, Ann Arbor
Kahn, Edgar A.....500 Burson Pl., Ann Arbor
Kambly, Arnold H., Jr.....201 S. Main St., Ann Arbor
Kaufer, Herbert (A)..1117 Maiden Lane Ct., Ann Arbor
Kaump, Donald H.....2800 Plymouth Rd., Ann Arbor
Keese, Antonia J.....705 N. University, Ann Arbor
Kelley, Paul A.....2513 Hampshire, Ann Arbor
Kemp, W. R., Jr.....8124 Main St., Dexter
Kenney, F. J., Jr. (A)....University Hospital, Ann Arbor
Kerlikowske, A. C.....1313 E. Ann St., Ann Arbor
Kern, Wheeler H.....P.O. Box 7, Garden City
Kerry, Robert L.....2695 Appleway, Ann Arbor
Kershul, Victor W.....Box A, Ypsilanti
Kimbrough, Wm. W.....2402 Brockman, Ann Arbor
Kittleson, Arthur C.....2111 Devonshire Rd., Ann Arbor
Kivi, Louis P.....2015 Manchester Rd., Ann Arbor
Klein, Charles M. (M).....U.S. Naval Hospital, Memphis 74, Tenn.
Knoll, Leo A. (R).....2002 Scottwood, Ann Arbor
Koepke, Geo. H.....1313 E. Ann St., Ann Arbor
Korst, Donald R.....460 Hillspur, Ann Arbor
Kraft, Richard O.....337 Lake Park Lane, Ann Arbor
Krausse, Chas. F.....502 Catherine Street, Ann Arbor
Krigbaum, Edmund M.....2253 Medford Rd., Ann Arbor

Lafler, C. J.....3835 Curlew Lane, Ann Arbor
Lampe, Isadore.....1313 E. Ann St., Ann Arbor
Lane, Alexander Z.....2233 Medford, Ann Arbor
Lapides, Jack.....1313 E. Ann St., Ann Arbor
LaVielle, Carroll J.....Hurley Hospital, Flint
Law, John L.....320 S. State St., Ann Arbor
Lawand, Frank K.....32377 Hazelwood, Wayne
Learned, David W.....1865 E. Ogden, Benton Harbor
Lease, Glenn O.....2800 Plymouth Rd., Ann Arbor
Lenhart, Benedict B. (A).....567 Hunt Rd., Ypsilanti
Levin, Robert H. (M)....3013 Blueford, Kensington, Md.
Lewis, Georgia A.....Ypsilanti State Hosp., Ypsilanti
Lindenauer, S. M. (A).....1414 Argyle Crescent, Ann Arbor
Litton, Ward B. (M).....102 Killarney, San Antonio 23, Texas
Lockett, Harold J.....319 Brookside Dr., Ann Arbor
Logan, Robert Gill (A).....317 W. Pueblo St., Santa Barbara, Calif.
Lovell, Robert G.....326 N. Ingalls St., Ann Arbor
Lowrey, Geo. H.....University Hosp., Ann Arbor
Lowry, Claud M.....1707 Shadford Rd., Ann Arbor
Lucas, Alexander R.....18471 Haggerty Rd., Northville

Magee, Kenneth R.....1313 E. Ann St., Ann Arbor
Magielski, John E.....2355 Londonderry Rd., Ann Arbor
Magnuson, Harold J.....1634 Univ. Medical Ctr., Ann Arbor
Malcolm, Karl D.....311 N. Ingalls St., Ann Arbor
Maley, John E.....5441 Walsh Rd., Whitmore Lake
Marshall, Mark (L).....1803 South Blvd., Ann Arbor
Martel, William.....1609 Glastonbury Rd., Ann Arbor
Martin, Donald W.....19 W. Michigan Ave., Ypsilanti
Mason, Joyce W.....1908 Scottwood, Ann Arbor
Mason, Stephen C., III.....820 E. University, Ann Arbor
Mathews, Kenneth P.....1145 Aberdeen Dr., Ann Arbor
McCabe, Brian F.....2545 Blueberry Lane, Ann Arbor
McCubbrey, David R.....905 W. Ann Arbor Trail, Plymouth
McDermott, J. F., Jr. (A)..1925 Austin Rd., Ann Arbor
McEachern, Thos. H.....1130 Hill St., Ann Arbor
McFarland, H. R., Jr. (A).....Suite 444 Wornall Road, Kansas City 11, Mo.
McGreer, J. T., III (A).....1821 Covington, Ann Arbor
McLean, James A.....1313 E. Ann St., Ann Arbor
McQuiggan, Mark C. (A).....1008 Island Dr. Ct., Ann Arbor
McWilliams, John R.....201 S. Main St., Ann Arbor
Meadows, Joseph M., Jr.....816 Westwood, Ann Arbor
Mella, Barbara A. (A).....721 S. State St., Ann Arbor
Meyen, Margaret (A).....2200 Fuller Rd., Ann Arbor

Miedler, Leo J.....University Hospital, Ann Arbor
Milford, A. F., Jr.....111 S. Prospect, Ypsilanti
Miller, Ira I.....15800 W. McNichols Rd., Detroit 35
Miller, Norman F.....1313 E. Ann St., Ann Arbor
Millman, Jerome I. (A).....19953 Weyher, Livonia
Moore, Robert A.....730 Northside Ave., Ann Arbor
Morley, Geo. W.....University Hosp., Ann Arbor
Morris, Joe D.....1313 E. Ann St., Ann Arbor
Moyyad, John.....740 S. Emerick St., Ypsilanti
Murphy, Miles J. (A).....3424 Edgewood, Ann Arbor
Murphy, Thomas C. (A).....Keesler Hospital, Keesler AFB, Biloxi, Miss.
Murray, Wm. A.....1705 Covington Dr., Ann Arbor

Nagler, Donald F. (A).....3185 Dwight, Ann Arbor
Nelson, Roger B.....1313 E. Ann St., Ann Arbor
Nesbit, Reed M.....Univ. Med. Cen., 303 Hosp., Ann Arbor
Newton, Chas. W., Jr.....115 E. Liberty St., Ann Arbor
Nixon, John C.....2144 Georgetown Blvd., Ann Arbor

O'Connor, Gerald....St. Joseph Mercy Hosp., Ann Arbor
O'Neal, Robert M. (A).....Univ. of Nebraska, Dept. of Surgery, Omaha 5, Nebr.
Ostrander, L. D., Jr.....2793 Manchester Rd., Ann Arbor
O'Sullivan, John.....2728 Yost Blvd., Ann Arbor

Pahucki, Gena R.....317 S. State St., Ann Arbor
Palmer, Algernon A. (L).....110 E. Middle St., Chelsea
Papo, Michael.....19377 Sibley Road, Chelsea
Parsons, Daniel B. (A).....USAREUR Med. Laboratory, A.P.O. 180, New York, N.Y.
Pattee, Bruce A. (A)....2915 Canterbury Rd., Ann Arbor
Payne, Beverly C.....425 E. Washington St., Ann Arbor
Pearson, Delbert E.....2274 Westaire Ct., Ann Arbor
Pelto, Maurice S. (A).....2226 Parkwood, Ann Arbor
Penner, John A. (A).....Simpson Memorial Inst., Ann Arbor
Perry, Burton L. (A).....2820 Beacon Hill, Ann Arbor
Peterson, Thomas R.....2015 Manchester Rd., Ann Arbor
Petrohelos, Manousos A.....27 S. Prospect St., Ypsilanti
Pierce, Edward C.....709 Madison Pl., Ann Arbor
Place, Edwin H.....Detroit Trans. GMC, Ypsilanti
Pletcher, Wm. D. (A)....350 Hiawatha Dr., Elkhart, Ind.
Pollard, H. Marvin.....2012 Vinewood Blvd., Ann Arbor
Pollard, John C.....1706 Chandler, Ann Arbor
Postmus, Roger W. (A).....130 Highlake, Ann Arbor
Potter, Marcia L.....318 W. Cross St., Ypsilanti
Proctor, Conrad A. (A)..1957 Coronada Dr., Ann Arbor
Prout, Gordon, J.....113 N. Ann Arbor St., Saline
Purfield, Wm. P.....Manchester

Quiroz, Hugo.....1414 Normandy St., Ann Arbor

Rae, James W., Jr.....1313 E. Ann St., Ann Arbor
Ransom, Henry K.....721 South Forest, Ann Arbor
Raphael, Theophile (L).....430 Hillspur, Ann Arbor
Rapp, Robert.....1460 Cedar Bend Dr., Ann Arbor
Ratliff, Rigdon K.....326 N. Ingalls St., Ann Arbor
Reed, Daniel L. (A).....2310 Fernwood, Ann Arbor
Regan, Wm. J., Jr.....326 N. Ingalls, Ann Arbor
Rehner, Robt. C.....103 E. Liberty St., Ann Arbor
Reichert, Rudolph E., Jr.....1046 Baldwin, Ann Arbor
Reinhart, Melvin J.....1921 Hampton St., Ann Arbor
Rekshan, Wm. R.....425 E. Washington St., Ann Arbor
Ritter, Frank N.....2230 Walter Drive, Ann Arbor
Robinson, Orlo J., Jr.....501 Dunlap, Northville
Robinson, Wm. D.....1313 E. Ann St., Ann Arbor
Ross, C. Howard (L).....715 N. University Ave., Ann Arbor
Ross, Leon (A).....Vet. Adm. Hospital, Ann Arbor
Rovner, David R. (A).....1811 Sunrise St., Ann Arbor
Russo, Sam F.....9551 Main St., Whitmore Lake

Saunders, Allen.....2361 E. Stadium Blvd., Ann Arbor
Sayre, Geo. S.....27 S. Prospect, Ypsilanti
Schaefer, Donald L.....201 E. Liberty, Ann Arbor
Schemm, George W. (A).....USAF Hosp., Box 514, Travis AFB, Calif.
Schlacht, Geo. F.....37064 Goddard Rd., Romulus
Schneider, Richard C.....1313 E. Ann St., Dept. N.S., Ann Arbor
Schoch, Henry K.....Vets. Admin. Hosp., Ann Arbor
Schroeder, Karl F. (A).....1706 Abbott, Ann Arbor
Schultz, E. C., Jr.....20172 Sheffield, Detroit 21
Schumacher, Wm. E.....201 S. Main St., Ann Arbor
Schunk, Herbert.....425 E. Washington St., Ann Arbor
Scovill, Henry A.....1313 W. Cross St., Ypsilanti
Seevers, Maurice H.....Univ. of Mich. Med. Sch., Ann Arbor
Segat, Maria Z.....455 Huntington Drive, Ann Arbor
Selzer, Melvin L.....1201 Red Oak Rd., Ann Arbor
Shadoan, James D.....385 Washington St., Chelsea
Sheldon, John M.....2121 Toumy Road, Ann Arbor
Shelton, John C.....25 N. Adams, Ypsilanti
Sheperdigian, A. A.....3841 Hamburg Rd., Brighton
Shoecraft, Harriet L.....425 E. Washington, Ann Arbor
Sigler, Louis E., Jr.....1443 Covington Dr., Ann Arbor
Singer, Robert P. (A).....800 Baldwin Rd., Richmond 29, Va.
Sink, Emory W. (L).....725 N. University Ave., Ann Arbor
Sirola, Olga.....1710 Collegewood, Ypsilanti
Skrentny, Thomas T.....1411 Pear St., Ann Arbor
Slee, Vergil N.....201 S. Main St., Ann Arbor
Sloan, J. Bernard (A).....1001 Island Dr., Apt. 104, Ann Arbor
Smillie, John W.....1335 Fairlane Dr., Ann Arbor
Smith, Donald C.....Univ. of Mich., Ann Arbor
Smith, Edwin M.....1815 Arbordale, Ann Arbor
Smith, Eleanor.....425 E. Washington St., Ann Arbor
Smith, M. F. W. (A).....4785 Lake Ct., Rt. 1, Ann Arbor
Sparling, Irene L. M.....251 E. Main St., Northville
Spencer, Herbert H.....526 Sixth St., Ann Arbor
Steel, William B.....6958 Town Lane, Dearborn
Steude, Georgine M. (A)....1511 Northwood, Ann Arbor
Stevens, Robert E. (A).....1109 S. Texas Bldg., San Antonio, Texas
Stewart, Bruce H.....University Med. Center, Ann Arbor
Straschnov, Geo. J.....29856 Schoenherr Rd., Warren
Struthers, James N. P.....Box A, State Hosp., Ypsilanti
Sturgis, Cyrus C. (L)....Simpson Mem. Inst., Ann Arbor
Sweet, Robt. B.....1313 E. Ann St., Ann Arbor

Tabar, Walter M. (A).....554 Fourth St., Ann Arbor
Taylor, Fulton B.....1107 S. Harris, Ypsilanti
Taylor, Wm. B.....326 N. Ingalls, Ann Arbor
Teed, R. Wallace.....215 S. Main, Ann Arbor
Thieme, E. Thurston.....St. Joseph Mercy Hosp., Ann Arbor
Thompson, A. S.....2432 Dorchester Rd., Ann Arbor
Thompson, George R.....1400 Traver St., Ann Arbor
Thorpe, Roger G. (A).....2700 Elmwood, Ann Arbor
Tipton, John B. (A).....2877 Burlington, Ann Arbor
Tiziani, Joseph J. (A).....Box A, Ypsilanti
Tourtellotte, W. W.....University Hosp., Ann Arbor
Towsley, Harry A.....Dept. of P.G. Med., Univ. of Mich., Ann Arbor
Tupper, Chas. J.....2490 Adare, Ann Arbor
Tupper, Robert L.....2305 Easy St., Ann Arbor
Van Brocklin, J. D. (A).....1048 Morningside Dr., Ann Arbor
Van Duzen, Verne L.....Box A, Ypsilanti
Van Reesema, F. S.....1608 Kirtland Dr., Ann Arbor
Van Schoick, R. M. (A)
Votaw, May Louise K.....629 Revena Pl., Ann Arbor
Vreede, P. D.....1020 Ferdon, Ann Arbor

Waggoner, R. Walter.....3333 Geddes Rd., Ann Arbor
Waldron, Alexander M.....309 N. Ingalls, Ann Arbor
Wallner, Julius M.....1313 E. Ann St., Ann Arbor
Watkins, Richard D.....2355 W. Delhi Rd., Ann Arbor
Watson, Ernest H.....University Med. Cen., Ann Arbor 8
Weber, William J. (A).....2710 Cumberland, Ann Arbor
Wegienka, L. C. (A).....Univ. of Calif. Med. Cen., San Francisco, Calif.
Weisman, Raoul L.....32 N. Washington, Ypsilanti
Weiss, Chas. F.....Box 1047, Ann Arbor
Weller, John M.....2508 Londonderry Rd., Ann Arbor
Westcott, Geo. W.....1515 S. Congress St., Ypsilanti

Westerberg, Martha R.....1313 E. Ann St., Ann Arbor
Westman, Jack C.....2727 Cranbrook Rd., Ann Arbor
Westover, Chas. J.....982 W. Ann Arbor Trail, Plymouth
Wetterstroem, Robt. G...46376 W. 7 Mile Rd., Northville
Whale, Edmund H.....207 Fletcher Ave., Ann Arbor
White, John D. (A).....2931 Burlington Ct., Ann Arbor
Whitehouse, W. M.....1313 E. Ann St., Ann Arbor
Whowell, Marianne.....1805 Ivywood Dr., Ann Arbor
Wicht, Paul J.....1385 W. Michigan, Ypsilanti
Wile, Udo J. (L).....201 S. Main St., Ann Arbor
Wilk, Lawrence H. (M).....507 Louise, Box 504, Copperas Cove, Texas
Williams, Howard R.....1950 Manchester Rd., Ann Arbor
Williamson, Fredk. B.....319 W. Michigan Ave., Ypsilanti
Willis, Park W., III.....University Hospital, Ann Arbor
Wilson, J. Leroy.....1313 E. Ann St., Ann Arbor
Wilson, William S.....526 Linden, Ann Arbor
Winkler, James M.....2015 Crestland Dr., Ann Arbor
Wisdom, Inez R. (L).....2301 Packard, Ann Arbor
Wolfman, Earl F., Jr.....2972 Park Ridge Dr., Ann Arbor
Wolter, J. Reimer....University Med. Center, Ann Arbor
Woo, Theresa T.....P. O. Box 1833, Ann Arbor
Woods, James J. (L).....19 N. Washington St., Ypsilanti
Woods, Scott W.....27 S. Prospect, Ypsilanti
Work, Walter P.....University Med. Center, Ann Arbor
Worth, Melissa H. C. (L)....R.F.D. 7, 3211 Packard Rd., Ann Arbor
Wright, Harold L.....18741 Haggerty, Northville
Wyman, John S.....2224 Highland Rd., Ann Arbor

Yoder, Orus R. (L).....Ypsilanti State Hosp., Ypsilanti
Youngblood, James P. (A).....802nd Medical Group, Schilling AFB, Kans.
Yull, Arthur B. (A).....University Hospital, Ann Arbor

Zarafonetis, C. J. D.....Simpson Mem. Inst., Ann Arbor
Zerbi, Victor M.....27 S. Prospect, Ypsilanti
Zrull, Joel P. (A).....630 Dartmoor, Ann Arbor
Zuidema, George D.....912 Honey Creek Dr., Ann Arbor

WAYNE COUNTY MEDICAL SOCIETY (222)

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Aboulafia, Elie D.....18241 Greenfield, Detroit 35
Abraham, Jos. P.....2799 W. Grand Blvd., Detroit 2
Acosta, Julio B.....25210 Grand River, Detroit 4
Adamian, Gerald D.....611 Kales Bldg., Detroit 26
Adams, James R.....14741 Michigan Ave., Dearborn
Adams, Vincent B.....15124 Kercheval, Grosse Pte. 30
Adelson, Seymour S.....18400 Schaefer Rd., Detroit 35
Adelson, Sidney L.....16221 Schoolcraft, Detroit 27
Adler, Sidney.....3011 W. Grand Blvd., Detroit 2
Agnew, Geo. H.....3011 W. Grand Blvd., Detroit 2
Agnone, Eugene J.....1420 St. Antoine St., Detroit 26
Aiuto, Jas. J.....660 Cadieux Rd., G.P., Detroit 30
Akroyd, Cecil.....16551 W. Warren, Detroit 28
Alban, Emil J., Jr.....7940 Allen Rd., Allen Park
Albrecht, Albert J.....4407 Roemer, Dearborn
Alexander, Allen.....18881 Hilton, Southfield
Alexander, Eugene J.....24140 Wilson, Dearborn
Alexander, G. D.....25799 Lathrup Blvd., Southfield
Alexander, L. C.....1204 Kales Bldg., Detroit 26
Alford, Elvis S.....105 Main St., Belleville
Allaben, Robert D...18255 W. McNichols Rd., Detroit 19
Allen, John V.....1336 Southfield Rd., Lincoln Park
Allison, Herbert C. (L).....383 Fisher Rd., Detroit
Alpern, E. Bryce.....2840 W. 7 Mile Rd., Detroit 21
Alpiner, Sam.....2850 E. Seven Mile Rd., Detroit 34
Altman, Jules.....14633 E. Seven Mile Rd., Detroit 5
Altman, Raphael.....17000 W. 8 Mile Rd., Southfield
Alvarez, Ana G.....Detroit Memorial Hosp., Detroit 26
Alvarez, Hernan, Jr.....Henry Ford Hosp., Detroit 2
Alvarez, Julian.....17380 Monica, Detroit 21
Amato, Robt. M. (A).....Grace Hospital, Detroit 1
Amos, Thos. G. (L).....641 Covington Dr., Detroit 3
Anastassiadis, C. T.....10030 Cadieux, Detroit 24
Anderson, Beverly L.....1064 Iroquois, Detroit 14
Anderson, Chas. P.....16733 Plainview Rd., Detroit 19
Anderson, James O.....7715 Middlepointe Ave., Dearborn
Anderson, Walter L.....1553 Woodward Ave., Detroit 26
Anderson, Wm. B., Jr.....17160 Freeland, Detorit
Andreou, Byron.....10 Peterboro, Detroit 1
Angel, John J.....34549 Main St., Wayne
Annessa, Domenico M. (L)..3536 Burns Ave., Detroit 14
Ansley, Mary K.....1 Lafayette Plaisance, Detroit 7
Appelman, Howard B...1553 Woodward Ave., Detroit 26
Arcari, Frederico A.....771 Fisher Bldg., Detroit 2
Archambault, Henry A. (A)....Jirapa, Gold Coast, Africa
Archambault, Rene F.....35550 Michigan Ave., Wayne
Arehart, Burke W.....11540 Morang Dr., Detroit 24
Arminski, Thos. C.....1066 Fisher Bldg., Detroit 2
Armstrong, Arthur G.....3001 W. Grand Blvd., Detroit 2
Armstrong, Mac J.....15125 Grand River, Detroit 27
Arnkoff, Morris.....18241 Greenfield, Detroit 35
Arnold, Effie E. (L).....16520 Oakfield, Detroit 35
Arnold, Wm. J., Jr.....8203 12th St., Detroit 6
Arrington, Robyn J.....7811 Oakland Ave., Detroit 11
Ascher, Meyer S.....1508 David Broderick Tower, Detroit 26
Ashe, Stilson R. (L).....8031 W. Vernor Hwy., Detroit 9
Ashley, Lowell B. (R).....5811 N.E. 21 Rd., Ft. Lauderdale, Fla.
Askar, Fawzy.....28055 Wellington, Farmington
Asselin, Regis F.....20480 Eastwood Dr., Detroit 36
Atler, Lawrence R.....681 W. Forest, Detroit 1
Auble, Max E.....2501 W. Grand Blvd., Detroit 8
August, Harry E.....1242 Maccabees Bldg., Detroit 2
Austin, Donald C.....320 Prof. Bldg., Detroit 1
Austin, Shirley.....5224 St. Antoine St., Detroit 2
Ausum, John D.....6420 Hartwell, Dearborn
Avrin, Ira.....10821 Puritan, Detroit 38
Axelrod, Arnold R.....15001 W. 8 Mile Rd., Detroit 35
Axelrod, Mildred A. (A)....13725 8 Mile Rd., Detroit 35
Axelrod, Robt. G. (A).....18518 Appoline, Detroit 35
Babcock, Lloyd K. (L).....16420 Schoolcraft Ave., Detroit 27
Babcock, Myra E.....7 Poplar Park, Pleasant Ridge
Babcock, Warren W.....868 Fisher Bldg., Detroit 2
Bach, Walter F. (L).....5419 Livernois Ave., Detroit 10
Bacher, Burton J.....1015 Kales Bldg., Detroit 26
Bachman, Morris E.....10326 W. 7 Mile Rd., Detroit 21
Bacon, Vinton A.....18400 Livernois, Detroit 21
Bader, Benj. H.....2654 W. Grand Blvd., Detroit 8
Baeff, Michael A. (R)....15435 Stahelin Ave., Detroit 23
Baer, Geo. J.....1553 Woodward Ave., Detroit 26
Baer, Marga.....16321 Mack Ave., Detroit 24
Baer, Walter.....16321 Mack Ave., Detroit 24
Bagley, Harry E. (A).....7541 Oakman Blvd., Dearborn
Bahra, Robt. J.....14300 W. McNichols, Detroit 35
Bailey, Louis J.....Northland Center, Southfield
Baima, Margaret A.....1212 David Whitney Bldg., Detroit 26
Baker, Clarence (L).....20832 Tuck Rd., Farmington
Bakst, Joseph A. (L).....10 W. Warren, Detroit 1
Balaga, Frank T.....9701 Joseph Campau Ave., Hamtramck 12
Balberor, Harry.....275 W. Grand Blvd., Detroit 16
Balcerski, Matthew A.....10 Peterboro St., Detroit 1
Ballard, Donald R.....22231 W. Outer Dr., Dearborn
Balow, Ross M.....18700 Meyers Rd., Detroit 35
Balser, Chas. W. (L).....13931 Gratiot, Detroit 5
Banish, Gerald.....23100 Cherry Hill, Dearborn
Barak, Lewis R.....7448 W. Seven Mile Rd., Detroit 21
Barak, Stuart.....18241 Greenfield, Detroit 35
Baran, Alphonse W.....15841 W. Warren St., Detroit 28
Barbaglia, Louis C.....16378 Harper, Detroit 24
Barber, Radivoj R.....864 S. Main St., Plymouth
Bardenstein, M. B.....17000 W. 8 Mile Rd., Southfield
Barefield, Alwin S.....8629 W. Eight Mile Rd., Detroit 21

Barenholtz, Benj.....1138 Maccabees Bldg., Detroit 2
Barker, David H.....7220 Gratiot Ave., Detroit 13
Barlow, Myron.....18050 Mack Ave., Grosse Pointe
Barnes, Van D. (R).....11040 Ingram, Livonia
Barnett, Louis L.....10 Witherell St., Detroit 26
Barnett, Morton.....1527 David Stott Bldg., Detroit 26
Barnhardt, R. A.....Ford Motor Co., Highland Park 3
Barone, C. Gerald.....15231 W. 7 Mile Rd., Detroit 35
Barrett, C. D., Jr.....316 City County Bldg., Detroit 26
Barrett, Raymond J.....18280 Fairfield, Detroit 21
Barrett, Wyman D. (L).....1553 Woodward Ave., Detroit 26
Barron, James.....2535 Amberly Rd., Birmingham
Barron, Wm. H.....14938 Livernois St., Detroit 38
Barsky, David.....100 Oak St., Wyandotte
Barton, Jos. R.....19619 W. Warren, Detroit 28
Baruch, Robert J.....18737 Hilton Rd., Southfield
Basel, Arthur R.....41001 Seven Mile Rd., Northville
Baskin, Sidney.....19207 Schafer Rd., Detroit 35
Batchelor, Melvin T.....18060 Conant, Detroit 34
Bates, Gaylord S.....861 Monroe Blvd., Dearborn
Battle, John M.....6904 Charlesworth, Dearborn 6
Bauer, A. Robt.....19268 Grand River Ave., Detroit 23
Bauer, Benedict J.....16451 Schoolcraft, Detroit 27
Bauer, Lester E.....4 Woodside Pk., Pleasant Ridge
Bauer, Ralph E.....Henry Ford Hospital, Detroit 2
Bauer, Raymond B.....1326 St. Antoine St., Detroit 26
Baugh, Richard H.....24216 Michigan Ave., Dearborn
Baumer, Moe.....10 Peterboro, Detroit 1
Baumgarten, Elden C. (L).....20867 Mack Ave., Grosse Pte. Woods 36
Baumgarten, Thos. W.....20867 Mack Ave., Grosse Pte. Woods 36
Baxter, Seymour.....19925 Livernois, Detroit 21
Bayles, John G.....14359 Michigan, Dearborn
Bazil, Gilbert M.....19345 W. McNichols, Detroit 21
Beach, Watson.....20815 Mack Ave., Detroit 36
Beam, A. Duane....20160 Mack Ave., Grosse Pte. Woods
Beamer, Geo. D.....14853 Michigan Ave., Dearborn
Beard, James E.....906 N. Highland, Dearborn
Beck, Stanley M., Jr.....13118 Fort St., Wyandotte
Becker, Abraham.....10 Witherell St., Detroit 26
Beckett, Peter G. S.....951 E. Lafayette St., Detroit 7
Beckett, Victoria L. (A)..1420 Anita, Grosse Pte. Woods
Becklein, Clarence L...14351 E. Warren Ave., Detroit 15
Beckman, Hugh.....20001 Greenfield, Detroit 35
Bedell, Archie A.....15545 Mack Ave., Detroit 24
Bedwell, Wm. L.....1249 Washington Blvd., Detroit 26
Beebe, Willard E.....20203 Ann Arbor Tr., Dearborn 6
Beekhuis, G. Jan.....1326 St. Antoine St., Detroit 7
Beeuwkes, L. E.....13014 Mackenzie Ave., Detroit 28
Behan, Robt. C.....500 Griswold St., Detroit 26
Beitman, Max R.....510 Kales Bldg., Detroit 26
Belanger, W. Geo.....1041 Harvard, Detroit 30
Belden, Darwin F.....2424 Puritan, Detroit 38
Bell, J. Kenner.....660 Woodward Ave., Detroit 26
Bende, Sandor F.....15863 Garfield, Allen Park
Beninson, Joseph.....Henry Ford Hospital, Detroit 2
Bennett, Germany E.....5144 Hastings St., Detroit 11
Bennett, Harry B.....17320 Livernois, Detroit
Bennett, H. Stanley.....29767 E. River Rd., Grosse Isle
Bennett, Sanford A...15301 W. 9 Mile Rd., Oak Park 37
Bennett, Zina B. (L).....10319 Lanark, Detroit 24
Bennish, E. Leo.....14438 W. Six Mile Rd., Detroit
Benson, Clifford D.....1553 Woodward Ave., Detroit 26
Benson, Davis A.....17563 Greenfield, Detroit 35
Benson, Paul J.....2355 Fort St., Lincoln Park
Benson, Virginia M.....16238 Snowden Ave., Detroit 35
Bentley, Wm. G.....50 Westminster, Detroit 2
Berge, Clarence A. (L).....878 Lakewood, Detroit 15
Berger, Edwin L.....7301 Schaefer Rd., Dearborn
Bergman, Murray S.....4400 Livernois Ave., Detroit 10
Berke, Sydney S.....3333 E. Jefferson, Detroit 7
Berlin, Allen B.....17000 W. 8 Mile Rd., Southfield
Berman, Charles.....Highland Pk. Gen. Hosp., Highland Park 3
Berman, Lawrence.....1401 Rivard St., Detroit 7
Berman, Robt. H.....2111 Woodward, Detroit 1
Berman, Sidney L.....60 W. Hancock, Detroit 1
Bernard, Walter G.....910 Chalmer, Detroit 15
Bernbaum, Bernard.....17320 Livernois, Detroit 21
Bernstein, Saml. S.....18200 Wyoming, Detroit 21
Berridge, William L.....Chevrolet Motor Co., Livonia
Berry, Jos. E.....19242 W. 7 Mile Rd., Detroit 19
Besancon, John H.....1510 Broderick Tower, Detroit 26
Best, Thos. H. E. (L)..9221 E. Jefferson Ave., Detroit 14
Betanzos, G.....2730 E. Jefferson Ave., Detroit 7
Bialik, Michael H.....14853 Michigan Ave., Dearborn
Bicknell, Frank B...938 David Whitney Bldg., Detroit 26
Bielawski, John G...825 David Whitney Bldg., Detroit 26
Bigman, Oscar.....18400 Schaefer Rd., Detroit 35
Bihl, John H.....15800 W. McNichols Rd., Detroit 35
Billingslea, Thos. H.....2175 Willis Ave. E., Detroit 7
Birch, John R.....925 David Whitney Bldg., Detroit 26
Birk, Robert E.....Henry Ford Hospital, Detroit 2
Birkam, Fred F.....7301 Schaefer Rd., Dearborn
Birkelo, Carl C. (R)....1630 Chestnut, Winter Park, Fla.
Birkhill, F. Ross.....31 Shady Hollow Dr., Dearborn
Birndorf, Leonard.....18317 John R St., Detroit 3
Bittker, Isadore I. (L)....3321 Rochester Rd., Royal Oak
Bittrich, Norbert M.....2500 W. Grand Blvd., Detroit 8
Black, Perry S. (L).....19431 Van Dyke Ave., Detroit 34
Black, Robert W.....641 David Whitney Bldg., Detroit 21
Blain, Alexander, III.....2201 E. Jefferson, Detroit 7
Blain, James H., Jr.....119 Kercheval Rd., Detroit 36
Blaine, Max.....13700 Woodward, Detroit 3
Blair, Wm. F.....81 E. Kirby St., Detroit 2
Blanchard, Gerald E.....Ford Motor Co., Dearborn
Blanchard, Russell S.....1 Lafayette Plaisance, Detroit 7
Blanks, Douglas H.....3955 Fort St., Lincoln Park
Blass, Norman H.....1800 Tuxedo, Detroit 6
Blatt, Ronald W.....300 Cadillac Sq. Bldg., Detroit 26
Bleier, Alfred.....13015 E. Warren Ave., Detroit 15
Bleier, Jos. (L).....7504 Dexter Blvd., Detroit 6
Bloch, Abraham.....2935 E. Milwaukee Ave., Detroit 11
Block, Duane L.....3001 Miller Rd., Dearborn
Block, Melvin A.....2799 W. Grand Blvd., Detroit 2
Blodgett, James B.....76 W. Adams St., Detroit 26
Blodgett, Wm. E. (L).....76 W. Adams Ave., Detroit 26
Blodgett, Wm. H.....74 W. Adams Ave., Detroit 26
Bloom, Albert.....6484 Chene St., Detroit 11
Bloom, Arthur R.....19140 Gloucester, Detroit 3
Bloom, Victor.....951 E. Lafayette, Detroit 7
Bloomberg, Sanford.....18916 Woodward Ave., Detroit 3
Bloor, Robert J.....2799 W. Grand Blvd., Detroit 2
Blum, George L.....18200 Wyoming, Detroit 21
Blumenthal, Frank S.....261 Brady, Detroit 1
Blumenthal, Franz L. (L).....3011 W. Grand Blvd., Detroit 2
Blumer, Abraham..21415 W. Eight Mile Rd., Detroit 19
Boccaccio, John L.....11532 Morang, Detroit 24
Boccia, James J.....15761 E. Warren, Detroit 24
Boddie, Arthur W.....2737 Chene St., Detroit 7
Bogucki, Chester J.....8110 Bliss, Detroit 34
Bogue, Robt. E.....15800 W. McNichols Rd., Detroit 35
Bogusz, Ladislaus (R).....29215 Maranya Rd., Homestead, Fla.
Bohn, Z. Stephen.....327 Professional Bldg., Detroit 1
Bohne, A. Waite.....Henry Ford Hospital, Detroit 2
Boland, John R. (R).....Box 50, Grand Marais
Boldt, Henry A., Jr.....1025 David Whitney Bldg., Detroit 26
Boles, Murray.....26381 Dundalk Lane, Farmington
Bolstad, Donald S.....Henry Ford Hospital, Detroit 2
Bolter, Sidney.....18946 W. McNichols, Detroit 19
Bolton, Russell P., Jr.....19566 Grand River Ave., Detroit 23
Boman, Robert H.....12650 E. Outer Dr., Detroit 24
Bookstein, Abraham M.....1475 Colton Ave., Detroit 3
Boone, Geo. F.....1328 Jolet, Detroit
Booth, Earnest.....Woman's Hospital, Detroit 1
Borchak, Robert G.....12408 Van Dyke, Detroit 34
Borden, Igor I.....15361 Plymouth Rd., Detroit 27
Borin, Maurice C.....18115 Fairfield St., Detroit 21
Bornstein, Sidney.....2033 Puritan, Detroit 3
Borrego, Jose M.....1777 Huntington, Grosse Pointe 36

Bott, Edmund T.....1629 Ford, Wyandotte
Botvinick, Isadore.....13701 W. 7 Mile Rd., Detroit 35
Boutrous, Thos. A.....15801 W. McNichols, Detroit 35
Bouza, Manuel A.....2329 E. Grand Blvd., Detroit 11
Bower, Donald W.....719 Liberty, Lincoln Park
Bowers, Leo J.....11200 E. McNichols Rd., Detroit 34
Bowlby, James R.....15420 Farmington Rd., Livonia
Bownes, Eugene A.....18520 Grand River, Detroit 23
Boyajian, Albert.....10963 Farmington, Livonia
Boyd, John H.....2615 W. Jefferson, Trenton
Boyle, Albert J.....Wayne St. University, Detroit 2
Boyle, Eugene H.....572 Thorn Tree Rd., Grosse Pte. Woods
Boyle, Robert E.....39630 Nine Mile Rd., Northville
Bracken, Andrew H.....5460 Schaeffer, Dearborn
Braden, Robt. G. (A).....25060 E. River Pl., Grosse Isle
Bradfield, Horace F.....3008 E. Grand Blvd., Detroit 2
Bradley, Geo. T.....1553 Woodward Ave., Detroit 26
Brady, Herbert A.....10593 W. Jefferson, River Rouge
Braley, Wm. N. (L).....12897 Woodward, Detroit 3
Bramigk, Fritz W. (L).....509-511 Prof. Bldg., Detroit 1
Brand, Benj.....4500 Wabash Ave., Detroit 8
Braun, Lionel.....15121 W. McNichols Rd., Detroit 35
Braun, Robert A.....18610 Hartwell Ave., Detroit 35
Braverman, Morris M.....20905 Greenfield Rd., Southfield 35
Bredau, Frank N., Jr.....24781 Fenkell, Detroit 29
Breiner, Sander J...14300 W. McNichols Rd., Detroit 21
Brekke, Viola G.....369 Glendale St., Highland Park 3
Bremer, John P.....17818 E. Warren, Detroit 24
Bremer, Wm. M.....15641 E. Warren, Detroit 24
Breneman, Gerald M.....16926 13 Mile Rd., Birmingham
Brennan, Michael J.....1176 Grayton, Detroit 30
Brent, Morris S.....1330 Strathcona Dr., Detroit 3
Bresnahan, Boyd K.....15800 W. McNichols Rd., Detroit 35
Brey, Norman W.....1900 David Broderick Tower, Detroit 26
Briegel, Walter A. (R)....1186 Buckingham, Birmingham
Briggs, Wm. J...1900 David Broderick Tower, Detroit 26
Bringard, Elmer L.....18110 Fairfield Ave., Detroit 21
Brinkman, G. L.....Henry Ford Hospital, Detroit 26
Briski, Jacob E.....21231 Sunnydale, St. Clair Shores
Brisson, Jos. C.....9191 Whittier St., Detroit 24
Bristol, Wm. R.....189 Claverly, Detroit 36
Broadman, Sylvan A.....25705 Middlebelt, Farmington
Brock, Donald R.....36475 Five Mile Rd., Livonia
Broderson, Harvey S. (R).....10720 W. Jefferson, River Rouge 18
Bromme, Wm.....10 Peterboro St., Detroit 1
Brooks, Chas. W., II.....2033 E. Davison St., Detroit 12
Brooks, Eugene M.....1103 Kales Bldg., Detroit 26
Brooks, Nathan.....904 Maccabees Bldg., Detroit 2
Brosius, Chas. O.....15800 Six Mile Rd., Detroit 35
Brosius, Wm. L. (L).....1823 Fair Oak Ct., Rochester
Brown, Andrew G.....18230 Grand River Ave., Detroit 23
Brown, Audrey O. (L).....46 Oakdale, Pleasant Ridge
Brown, Carlton F...16552 Westmoreland Rd., Detroit 19
Brown, Chas. H.....2387 Fort St., Wyandotte
Brown, Eli M.....13123 LaSalle, Huntington Woods
Brown, Frances.....1940 Lincolnshire, Detroit 3
Brown, Gordon T.....13000 Hayes Ave., Detroit 5
Brown, Henry S. (L).....18101 Jas. Couzens Hwy., Detroit 35
Brown, H. Zane (A).....Receiving Hospital, Detroit
Brown, John R.....1145 David Whitney Bldg., Detroit 26
Brown, Robt. A.....3529 W. Jefferson, Detroit 29
Brown, Saml. M.....21821 Harding, Oak Park
Brown, Saul.....6890 White Pine Dr., Birmingham
Brown, Stanley H.....8544 W. McNichols Rd., Detroit 21
Brown, Thos. A.....5430 W. Warren Ave., Detroit 10
Brownell, H. H.....10435 Groh, Grosse Isle
Brownell, Paul G.....18916 Woodward Ave., Detroit 3
Bruce, Thomas A.....16540 Shrewsbury, Detroit 21
Bruder, Robt. C.....4520 Firestone Ave., Dearborn
Bruer, Edgar S.....12170 Fort St., Wyandotte
Bruer, Edwin L.....12170 Fort St., Wyandotte
Brundage, Robt. D.....1914 Edgewood, Dearborn
Brush, Brock E.....2799 W. Grand Blvd., Detroit 2
Bruton, Martin F.....341 Massachusetts, Detroit 31
Bryan, Donald I.....13700 Woodward Ave., Highland Park 3
Bryan, John B.....2799 W. Grand Blvd., Detroit 2
Bryce, John D.....Med. Dispensary APO, Detroit 33
Budson, Danl.....10330 W. Seven Mile Rd., Detroit 21
Buell, John H. (R).....188 Provencal Rd., Detroit 36
Buerki, Robin C.....Henry Ford Hospital, Detroit 2
Buettgen, Jan W.
Buller, Harry L. (A).....4120 Fenkell Ave., Detroit 38
Burge, Robert H.....28343 Joy Rd., Dearborn
Burke, Ralph M.....580 University Pl., Grosse Pte. 30
Burnham, David C.....13700 Woodward Ave., Highland Park
Burns, Robert E.....Henry Ford Hospital, Detroit 2
Burns, Robt. T.....11110 Morang Rd., Detroit 24
Burnside, Howard B.....33 Oakland Park, Pleasant Ridge
Burnstine, Julius Y. (L).....45 Owen Ave., Detroit 2
Burnstine, Perry P.....2329 W. Grand Blvd., Detroit 8
Burr, Geo. C. (L).....2016 W. Boston Blvd., Detroit 6
Burroughs, Roswell G.....31624 Auburn Dr., Birmingham
Burrows, Howard A.....10423 W. Warren Ave., Dearborn
Burstein, Harry S.....2950 W. Grand Blvd., Detroit 2
Burstein, I. Marvin.....2950 W. Grand Blvd., Detroit 2
Burstein, Morris M.....2950 W. Grand Blvd., Detroit 2
Burton, DeWitt T. (L).....54 Arden Park, Detroit 2
Burton, Irving F.....26912 York Rd., Huntington Woods
Burton, John F.....V.A. Hospital, Dearborn
Bush, Glendon J.....18901 W. McNichols, Detroit 19
Butler, Harry J. (L)....33 Waverly Ave., Highland Park
Butler, James E.....2177 W. Grand Blvd., Detroit 8
Butler, John D.....2173 W. Grand Blvd., Detroit 8
Butler, J. Payne.....3403 W. Warren St., Detroit 8
Butler, Lawrence H.....14521 E. 7 Mile Rd., Detroit 5
Butler, Richard G.....2021 Monroe, Dearborn
Butler, Volney N.....28 W. Adams Ave., Detroit 26
Byers, Dudley W. (A).....8934 Oakland, Detroit 11
Cadieux, Henry W. (L)..899 Westchester, Grosse Pte. 30
Cahalan, Jos. L.....15830 Fort St., Southgate
Cain, Waldo L.....8401 Woodward Ave., Detroit 2
Caldwell, Geo. L. (L)..12017 Joseph Campau, Detroit 12
Caldwell, John R.....2799 W. Grand Blvd., Detroit 2
Cameron, Arthur H. (L)....2853 Biddle Ave., Wyandotte
Cameron, Duncan A.....2021 Monroe, Dearborn
Cameron, George H.....15120 Michigan Ave., Dearborn
Campbell, Duncan (L).....330 Bush St., Apt. 1, Howell
Campbell, Everett W.....7901 W. Jefferson, Detroit 17
Campbell, Harvey E.....25525 Graceland Dearborn Heights
Campbell, Malcolm D. (L).....14950 Forrer, Detroit 27
Campbell, Mary B. (L).....10454 Kingston, Huntington Woods
Campbell, Robt. E.....8445 E. Jefferson Ave., Detroit 14
Campbell, Ruth B.....1536 David Whitney, Detroit 26
Campbell, Thelma M.....2355 Monroe Blvd., Dearborn
Candler, Clarence L.....20040 Mack Ave., Detroit 36
Canter, Gayle E.....26 Waverly, Detroit 3
Cantor, Herbert C. 26831 N. Woodward, Huntington Woods
Cantor, Meyer O.....26831 Woodward Ave., Huntington Woods
Cantow, Lawrence A...19291 Warrington Dr., Detroit 21
Capellari, Elmer E.....Box 3059, Detroit
Caputo, Jos. M.....21831 Willoway, Dearborn
Caputo, Nancy T.....17712 Mack Ave., Grosse Pte. 30
Capuzzi, Eugene T.....24644 Gleneyrie Dr., Southfield
Caraway, James E. (R).....35804 John R St., Wayne
Carbone, Louis.....14711 Gratiot Ave., Detroit 5
Carbonell, Tomas.....353 Devonshire, Dearborn
Carlisle, John C.....15101 Southfield, Allen Park
Carlson, Harold W.....18070 Wildemere Ave., Detroit 21
Carnes, Harry E.....Parke Davis Co., Detroit 32
Carp, Jos.....8717 Van Dyke, Detroit 13
Carpenter, C. J.....P.O. Box 390, Wayne
Carpenter, Glenn B. (L).....2751 W. Seven Mile Rd., Detroit 21
Carpenter, Wm. S...18255 W. McNichols Rd., Detroit 19

Carr, James G. (L).....14111 Korte, Detroit 15
Carrick, Lee.....18050 Mack Ave., Grosse Pte.
Carroll, Elmer H.....9920 Stoepel Ave., Detroit 4
Carroll, Jerome G.....19723 Dale, Detroit 19
Carroll, Lona B. (L).....938 David Whitney Bldg., Detroit 26
Carruthers, W. B.....2900 S. Fort St., Detroit 17
Carson, Herman J.....7745 Puritan Ave., Detroit 38
Carstens, Henry R. (L).....6896 N. Clunbury Rd., Birmingham
Carter, James A. U.....16637 Wildemere, Detroit 21
Carter, John M. (L).....18900 Fairway Dr., Detroit 21
Carter, Leland F.....750 Middlesex, Detroit 30
Cash, Ralph.....19316 James Couzens Hwy., Detroit 35
Cassel, Harry E.....6742 Park Ave., Allen Park
Castle, Maurice E.....18980 Wyoming, Detroit 21
Caughey, Andrew F., Jr.....20041 W. Eight Mile Rd., Detroit 19
Caughey, Edgar H.....11301 Whittier St., Detroit 24
Caumartin, Fred E.....17184 Wildemere, Detroit 21
Cellar, Frank A., Jr.....6789 Woodward Ave., Royal Oak
Ceravolo, Albert J.....468 Cadieux Rd., Detroit 30
Cetnar, Eugene J.....4322 Bishop, Detroit 24
Chajes, Richard.....16850 Joy Rd., Detroit 28
Chalat, Ned I.....1553 Woodward Ave., Detroit 26
Chall, Henry G.....2941 W. McNichols Rd., Detroit 21
Chapin, Sidney E.....125 N. Military, Dearborn 7
Chapman, Aaron L. (L)
Chapman, Paul T.....1151 Taylor Ave., Detroit 2
Chapman, Roland H.....7600 John R St., Detroit 2
Chapman, Thomas H.....18901 Grand River Ave., Detroit 23
Chapnick, Henry A.....19322 Wyoming, Detroit 21
Chapper, Barbara M.....861 Monroe, Dearborn
Charnas, Sidney..1129 David Whitney Bldg., Detroit 26
Chase, Clyde H. (R).....2922 Dawes St. S.E., Grand Rapids 8
Chason, Jacob L.....1401 Rivard St., Detroit 7
Chavis, William M.....15866 12th St., Detroit 21
Check, Frank E.....76 W. Adams Ave., Detroit 26
Chen, Allen S. Y.....Wayne Co. Gen. Hosp., Eloise
Chen, Calvin H.....State Hospital, Northville
Chen, Shek C.....1326 St. Antoine, Detroit 26
Chen, Vincent V.....987 E. Jefferson, Detroit 7
Chesluk, Herman M.....17191 James Couzens Hwy., Detroit 35
Chester, Alice.....25085 Coolidge Hwy., Oak Park
Chester, Wm. P.....28 W. Adams Ave., Detroit 26
Childs, Geo. M.....2970 W. Grand Blvd., Detroit 2
Chipman, Willard A.....14300 W. McNichols Rd., Detroit 35
Chipoco, Adolfo M.....25210 Grand River, Detroit 40
Chostner, Grover C. (R).....841 Eden Isle Blvd., St. Petersburg, Fla.
Chown, Marion C.....2025 Ford, Wyandotte
Christensen, R. C.....19635 Mack, Grosse Pte. Woods
Christopher, James G.....4777 E. Outer Dr., Detroit 34
Chrouch, Laurence A. (L).....Pleasant Hill, Tenn.
Church, Aloysius S.....19570 Bretton Dr., Detroit 23
Churchill, John A.....Lafayette Clinic, Detroit 7
Cioffari, Mario S.....15924 W. 7 Mile Rd., Detroit 35
Ciprian, Jos. E.....1775 E. Grand Blvd., Detroit 11
Clapper, Muir.....1401 Rivard St., Detroit 7
Clark, Arthur M.....401 River Lane, Dearborn
Clark, Chas. J.....510 Hughes Rd., Howell
Clark, Clarence M. (L)..2605 Holbrook Ave., Detroit 12
Clark, Harold E. (L)....30761 Greenfield Rd., Southfield
Clark, Max D.....Henry Ford Hospital, Detroit 2
Clark, Wm. P.....1808 Baldwin, Ann Arbor
Clarke, Chas. N.....2501 W. Grand Blvd., Detroit 8
Clarke, Norman E. (L)..2501 W. Grand Blvd., Detroit 8
Clarke, Norman E., Jr...2501 W. Grand Blvd., Detroit 8
Clarke, Robt. B.....76 W. Adams Ave., Detroit 26
Clermont, Volna.....5050 Joy Rd., Detroit 4
Clifford, Geo. O., Jr.....Wayne Univ. Coll. of Med., Detroit 7
Clifford, John E.....2108 David Broderick Tower, Detroit 26
Clifford, Thos. P. (L).....1750 David Whitney Bldg., Detroit 26
Climie, Andrew R. W.....Harper Hospital, Detroit 1
Cline, Richard S.....15101 Plymouth Rd., Detroit 27
Coan, Glenn L. (L)..2336 Van Alstyne Blvd., Wyandotte
Coates, E. Osborne, Jr.....Henry Ford Hospital, Detroit 2
Cobane, John H.....10 Peterboro Ave., Detroit 1
Cochrane, Edgar G.....503 Med. Arts Bldg., Detroit 3
Cocorelis, S. G.....33000 Palmer, Wayne
Cohen, Herbert H.....12700 W. 7 Mile Rd., Detroit 35
Cohen, Melvin F.....28590 Rivercrest Dr., Southfield
Cohn, Danl. E.....409 Fox Bldg., Detroit 1
Cohn, S. Leonard.....19105 W. 7 Mile Rd., Detroit 19
Cohoe, Don A. (L).....18916 Woodward Ave., Detroit 3
Cole, James E.....344 Glendale Ave., Detroit 3
Cole, Wyman C. C. (L).....1063 Fisher Bldg., Detroit 2
Cole, Wyman C. C., Jr...3011 W. Grand Blvd., Detroit 2
Coleman, Margarete W. (L).....1209 S. Woodward, Royal Oak
Coleman, Peter F.....31410 Joy Rd., Livonia
Coleman, Wm. G.....20526 Grand River Ave., Detroit 19
Coles, Thomas B., Jr.....Grace Hospital, Detroit 1
Collier, Beverly A.....Henry Ford Hosp., Detroit 2
Collings, M. Raymond (A).....9201 W. Outer Drive, Detroit 19
Collins, James E.....13103 W. Chicago Blvd., Detroit 28
Colvin, Leslie T.....3011 W. Grand Blvd., Detroit 2
Colyer, Raymond G.....284 Pilgrim, Birmingham
Combs, Julius V. (A)....Det. Receiving Hosp., Detroit 26
Comly, Hunter H.....5475 Woodward, Detroit 2
Compton, Wm. A., Jr.....36825 Bibbins, Romulus
Comstock, Lawrence A.....2299 West Road, Trenton
Conklin, Emma J.....Wayne Co. Gen. Hosp., Eloise
Conley, Lowry C. M. (L).....99 Tuxedo Ave., Detroit 3
Connelly, Richard C.....1401 David Wh. Bldg., Detroit
Connolly, Paul J.....16778 Westmoreland Rd., Detroit 19
Connors, John J.....3546 Trumbull Ave., Detroit 8
Cook, James A.....2246 20th Street, Wyandotte
Cook, James C.....3825 Brush St., Detroit 1
Cookinham, Frank.....999 S. Highland, Dearborn
Cooksey, Warren B.....801 Adams Rd., Birmingham
Cooper, James B.....18150 Mack Ave., Grosse Pointe 30
Cooper, Ralph R.....850 Lakeland, Grosse Pointe 30
Cooper, Richard F.....23130 Wilson, Dearborn
Corbeille, Catherine.....3011 W. Grand Blvd., Detroit 2
Corbett, David P.....Harper Hospital, Detroit 1
Cortez, Joseph A.....19350 W. McNichols, Detroit 15
Costa, Frank.....16805 Windmere Circle, Southgate
Costello, Russell T.....3001 W. Grand Blvd., Detroit 2
Costello, Stephen D.....2031 West Road, Trenton
Cotant, John F.....14341 W. McNichols, Detroit 35
Cotton, Schuyler O. (R)....7904 Vernor Hwy., Detroit 9
Coulter, Wm. J.....5258 Chatsworth, Detroit 24
Courville, Chas. J...703 Northland Med. Bldg., Southfield
Cowan, Wilfrid.....14239 Chandler Pk. Dr., Detroit 13
Cowen, Leon B. (L).....1001 Kales Bldg., Detroit 26
Cowen, Robt. L.....91 E. Kirby, Detroit 2
Cox, Frank, Jr.....Henry Ford Hospital, Detroit 2
Coyle, James E.....573 Fisher Bldg., Detroit 2
Craig, Roy E.....74 Fontana Lane, Grosse Pte. Shores
Craig, Roy D.....829 Fisher Bldg., Detroit 2
Crawford Robert I. (A).....Lyons
Crawley, Eugene H.....885 Bloomcrest, Birmingham
Crews, Thos. H. (L).....3011 W. Grand Blvd., Detroit 2
Crockett, E. E. J.....7341 W. Warren, Detroit 10
Croll, Leo J.....12703 W. 7 Mile Rd., Detroit 35
Croll, Maurice.....12703 W. 7 Mile Rd., Detroit 35
Crook, Chas. L.....60 Colorado St., Highland Park 3
Cross, Harold E.....68 N. Deepland Rd., Grosse Pointe
Crossen, Robert J.....933 David Wh. Bldg., Detroit
Croushore, James E.....3001 W. Grand Blvd., Detroit 2
Cubberley, Robt. B.....1800 Tuxedo St., Detroit 6
Cueto, Jose M.....4342 W. Vernor, Detroit 9
Cullis, Frank.....261 Brady, Detroit 1
Curhan, Jos. H.....18709 Meyers Rd., Detroit 35
Curtis, Frank E. (L).....10 Peterboro St., Detroit 1
Curtiss, Wm. P..... ..22631 Mack Ave., St. Clair Shores

Cusick, Paul L.....1108 Stroh Bldg., Detroit 26
Czuj, John M.....17198 Oak Dr., Detroit 21

Daignault, F. M.....14300 W. McNichols Rd., Detroit
Daitch, Martin H...13011 W. McNichols Rd., Detroit 35
Dale, Esther H.....1401 Rivard St., Detroit 7
Dale, Mark.....3702 E. 8 Mile Rd., Detroit 34
Dal Santo, G.....1800 Tuxedo, Detroit 6
Daly, Eugene T.....24781 Fenkell, Detroit 29
Danforth, James C., Jr.....20175 Mack Ave., Detroit 36
Danforth, Robt. D.....20175 Mack Ave., Detroit 36
Danz, George W.....1539 Ford, Wyandotte
Daoust, Patrick H.....15520 Garfield, Allen Park
Darling, Chas. E.....673 Fisher Bldg., Detroit 2
Darnley, James D.....2799 W. Grand Blvd., Detroit 2
Dashiell, Grayson F.....1800 Tuxedo, Detroit 6
Davidson, David M.....3011 W. Grand Blvd., Detroit 2
Davidson, Harold H.....19310 Wyoming, Detroit
Davidson, Harry O.....2799 W. Grand Blvd., Detroit 2
Davies, Thos. S. (L).....15115 E. Jefferson, Grosse Pointe 30
Davies, Windsor S.....28 W. Adams Ave., Detroit 26
Davis, Herbert A.....9901 Melbourne, Allen Park
Davis, Wm. N.....1250 Middlebelt Road, Inkster
Dawson, W. A. (R).....188 Lake Silver Dr. N.W., Winter Haven, Fla.
Day, A. Jackson.....245 Cloverly Rd., Detroit 36
Day, Francis T.....18540 Mack, Detroit 36
Day, Jay C.....1553 Woodward Ave., Detroit 26
Dean, Carleton R. (M).....Office of Vocational Rehab., 42 Broadway, Room 1200, New York 4, N.Y.
Dean, George A.....19309 Greenfield, Detroit 35
DeBusk, Roger W.....4160 John R. St., Detroit
Deering, Robt. J.....1359 Champaign, Lincoln Park
Defever, Cyril R.....19787 Mack Ave., Detroit 36
DeGiustino, Caesar.....1175 E. Grand Blvd., Detroit 11
DeGroat, Albert F.....1151 Taylor Ave., Detroit 2
Delaini, Stella M.....3011 W. Grand Blvd., Detroit 2
Delaney, James R...1737 Dav. Whitney Bldg., Detroit 26
DeLawrence, Betty J.....21576 Michigan Ave., Dearborn
DeLawrence, Thomas....21576 Michigan Ave., Dearborn
Del Giorno, Thos. E.....St. Johns Hospital, Detroit 36
Del Valle, Mario.....19936 Packard, Detroit 34
Dennis, Melvin S.....22146 Ford Rd., Dearborn
Deponio, Sylvester A...20215 Van Dyke Ave., Detroit 34
Deresz, Alphonse R.....4204 E. Outer Dr., Detroit 34
Derleth, Paul E.....563 W. Oakridge Ave., Ferndale 20
Derr, John W.....1145 Dav. Whitney Bldg., Detroit 26
Derrick, C. F.....3677 Fort Street, Lincoln Park
DeSmyter, Geo. C.....15527 E. Warren, Detroit 24
DeSpelder, Ray E.....2970 W. Grand Blvd., Detroit 2
Deuby, Owen J.....15121 W. 7 Mile Rd., Detroit
Devine, Herbert W.....22101 Moross Rd., Detroit 36
Diakow, Lillian M.....1539 N. Line Rd., Wyandotte
Dibble, Harry F. (L)....1553 Woodward Ave., Detroit 26
Dickson, Basil R.....337 W. Grand Blvd., Detroit 16
Dickson, Elias L., Jr.....7716 Oakland Ave., Detroit 11
Dickson, Laurie C., Jr.....400 Lincoln Rd., Grosse Pointe 30
Dickson, Leon A.....5535 W. Chicago, Detroit 4
Dickson, Mary D.....18424 Mack Ave., Grosse Pointe 36
Diebel, Nelson W.....660 Cadieux Rd., Detroit 30
Diekman, Fred C.....15800 W. McNichols Rd., Detroit 35
Dietze, Margaret R.....861 Monroe, Dearborn
Dietzel, Hugo O. (R).....844 Hemlock Dr., San Carlos, Calif.
DiLella, Leonard L.....Henry Ford Hosp., Detroit 2
Dill, Hugh L.....16114 E. Warren Ave., Detroit 24
Dill, J. Lewis.....18615 Birchcrest, Detroit 21
DiLoreto, Panfilo C.....285 Vincennes Pl., Detroit 36
DiMaso, Gennaro J.....21501 Kelly, East Detroit
Dimond, Geo. E.....18401 Bretton Dr., Detroit 23
Dionne, Paul E.....1308 Kales Bldg., Detroit 26
Dittmer, Edwin F.....18412 Mack Ave., Detroit 36
Ditzler, John W.....581 Rivard Blvd., Detroit 30
Dixon, Fredk. W.....245 S. Martha, Dearborn
Dixon, Ray S. (L).....5001 Van Dyke, Detroit 13
Dodds, John C. (L).....30 Morand Road, Detroit 36
Dodenhoff, Chas. F.....18031 Kelly Rd., Detroit 24
Dodrill, Forest D.....Woodberry Dr., Bloomfield Hills
Doering, Wendell R.....17555 James Couzens, Detroit 35
Doig, Victor F.....19676 Dale, Detroit 19
Dolan, Edward A.....22345 Cherry Hill, Dearborn
Dolega, Stanley F.....15640 E. Warren Ave., Detroit 24
Dolgoff, Sidney.....15600 Michigan Ave., Dearborn
Dolin, Simon.....2900 S. Fort St., Detroit 17
Domzalski, Casimir A...5361 McDougall Ave., Detroit 11
Domzalski, Henry M.....15252 Gratiot Ave., Detroit 5
Donald, Douglas.....7815 E. Jefferson Ave., Detroit 14
Donath, Rolf W.....7430 Second, Detroit 2
Donovan, Eugene T.....13365 Michigan Ave., Dearborn
Donovan, Richard S.....17555 James Couzens, Detroit 35
Doran, John H.....15101 Plymouth Rd., Detroit 27
Dorman, Jack.....18245 Warrington Dr., Detroit 21
Dorsey, John M.....65 Moss Avenue, Highland Park 3
Doty, Chester A. (L)....1553 Woodward Ave., Detroit 26
Doub, Howard P. (L)....2799 W. Grand Blvd., Detroit 2
Douglas, Clair L. (L)..1553 Woodward Ave., Detroit 26
Douglass, Robt. C.....23023 Orchard Lake Rd., Farmington
Dovitz, Benj. W.....16820 Greenfield Ave., Detroit 35
Dowdle, Edward (L).....2258 W. Grand Blvd., Detroit 8
Downer, Ira G. (L)....8445 E. Jefferson Ave., Detroit 14
Downes, Geo. O.....15062 Houston, Detroit 5
Drake, Ellet H.....Henry Ford Hospital, Detroit 2
Drake, James J. (R).....8845 Marygrove Dr., Detroit 21
Drapiza, Ruth L.....22231 W. Outer Dr., Dearborn
Draves, Edward F.....19647 Joy Rd., Detroit 28
Drazek, Jos. A.....18980 Wyoming, Detroit 21
Drews, Robt. S.....12500 Broadstreet Blvd., Detroit 4
D'Sena, Dorothy.....35084 Chestnut, Wayne
Dubin, Jos. J.....10401 W. Chicago Blvd., Detroit 4
Dubnove, Aaron (L).....2115 W. Grand Blvd., Detroit 8
Dubpernell, Martin S. (L)....4019 Gilbert St., Detroit 10
Dubpernell, Robt. O.....18595 Grand River, Detroit 23
Dudek, John J.....19244 Grand River, Detroit 23
Dumke, Paul R.....2799 W. Grand Blvd., Detroit 2
Duncan, James R.....8633 John R St., Detroit 2
Dundas, Edward M., Jr.....4520 Firestone, Dearborn
Dunlap, Henry A.....7815 Jefferson Ave. E., Detroit 14
Dunn, Cornelius E.....3496 Burns, Detroit 14
Dupler, Gerald E.....10 Peterboro, Detroit 1
Durham, Everett W...23100 Cherry Hill Rd., Dearborn 7
Durham, Robt.....Henry Ford Hosp., Detroit 2
Durocher, Edmund J. (L).....4158 W. Jefferson Ave., Ecorse 18
Dutcher, Dwight J.....711 S. Oxford, Detroit 36
Duwe, Frank A.....25296 Fenkell, Detroit 39
Dwaihy, Paul J.....14530 E. Warren, Detroit 15
Dwyer, Francis W.....14440 W. McNichols, Detroit 35
Dyer, H. Lorne.....718 Grandview, Northville
Dykema, Rosemary M.....18424 Mack Ave., Detroit 36
Dziuba, John F.....18901 W. Warren Ave., Detroit 28
Dzul, Paul.....14620 E. 7 Mile Rd., Detroit 5

Eades, Chas. C.....19635 Mack Ave., Detroit 36
Eadie, Gordon A.....16083 Southampton St., Livonia
Eakins, F.J. (R).....Henderson County, Robards, Ky.
Easterly, Robt. L.....1404 Ford Avenue, Wyandotte
Eaton, Crosby D.....3011 W. Grand Blvd., Detroit 2
Echt, Raymond J.....V.A. Hospital, Dearborn
Eckhous, Arthur W.....1015 Kales Bldg., Detroit 26
Economy, Donald E.....7854 Kentucky, Dearborn
Eder, Saml. J. (L).....941 Morton Rd., Detroit 3
Edgar, Irving I.....1036 David Whitney Bldg., Detroit 26
Edmonds, Gerald W.....19795 St. Marys Ave., Detroit 35
Edmonds, Wm. N. (L).....18525 Merriman Rd., Livonia
Edmondson, Robt. B.....18501 Mack Ave., Detroit 36
Edwards, James G.....17751 E. Warren Ave., Detroit 24
Egan, Charles F.....Wyandotte Gen. Hosp., Wyandotte
Eisenbrey, A. B.....Henry Ford Hosp., Detroit 2
Eisenstein, B.....210 Professional Bldg., Detroit 1
Eisman, Clarence H. (L).....1121 Whittier Rd., Grosse Pointe 30
Eldredge, Edward F.....18540 Mack Ave., Grosse Pointe 36

Elliott, Robt. N.....760 Fisher Bldg., Detroit 2
Ellis, Frank R.....800 S. Lafayette, Dearborn 7
Elman, Meyer J.....108 W. Hancock, Detroit
Elson, Abraham L. (A)..20236 Westmoreland, Detroit 19
Elvidge, Robt. J.....2900 W. Grand Blvd., Detroit 2
Emmert, Herman C. (L)..4927 N. 34th, Arlington 7, Va.
Endler, Gerhard C...1394 Roslyn Rd., Grosse Pte. Woods
Enfroy, Henri L.....19980 Shrewsburg, Detroit 21
Engel, Earl H.....2336 Van Alstyne Blvd., Wyandotte
Engstrom, Fredk. W.....2021 Monroe, Dearborn
Engstrom, Ruby M.....1777 Culver Ave., Dearborn
Eno, Laurel S.....212 Eastland Pr. Bldg., Detroit 36
Ensign, Dwight C.....Franklin
Erickson, Eldon W.....25750 W. Outer Dr., Lincoln Park
Erickson, Miles A.....1932 Ford Ave., Wyandotte
Erman, Jos. M.....19530 Stratford Rd., Detroit 21
Ernest, Reginald H.....5050 Joy Rd., Detroit 4
Eschbach, Jos. W.....935 S. Military St., Dearborn
Eurs, Frank J.....1340 Maccabees Bldg., Detroit 2
Evans, E. Warren.....5050 Joy Rd., Detroit 4
Evans, Gomer P., Jr.....1553 Woodward Ave., Detroit 26
Evans, Jos. M.....16431 Harper, Detroit 24
Ewing, Chas. H.....17120 E. Warren, Detroit 24
Eyler, Wm. R.....2799 W. Grand Blvd., Detroit 2
Eyres, Alfred E.....17800 E. 8 Mile, Detroit 36

Fachnie, Harold L..... ..19203 Grand River, Detroit 23
Faello, Sebastian J.....16840 E. Warren Ave., Detroit 24
Fagin, Irving D.....18254 Livernois Ave., Detroit 21
Fahim, Ramfis, B.....226 Eastland Prof. Bldg., Detroit 36
Failing, John F., Jr.....Wayne Co. Gen. Hospital, Eloise
Falick, Mordecai L.....3011 W. Grand Blvd., Detroit 2
Falk, Ira E.....17411 Cherrylawn, Detroit 21
Fallis, Lawrence S.....2799 W. Grand, Detroit 2
Fandrich, Theodore S. (R).....3515 Chuparosa Dr., Santa Barbara, Calif.
Farbman, Aaron A.....14515 Kercheval, Detroit 15
Farmer, Wm. L., Jr.....3335 W. Davison, Detroit 38
Farnam, Larry M., Jr.....19787 Mack Ave., Detroit 36
Faunce, Sherman P.....1824 Seminole St., Detroit 14
Fea, John F.....Mt. Carmel Mercy Hosp., Detroit 35
Feigelson, Howard H.....Sinai Hospital, Detroit 35
Felcyn, W. Geo.....2091 W. Grand Blvd., Detroit 8
Feld, David.....15101 W. McNichols Rd., Detroit 35
Feldkamp, Lee E.....360 N. Main, Plymouth
Feldman, Nathanial L.....24370 Tamarack Circle, Southfield
Feldman, Paul H.....16800 Greenfield, Detroit 35
Feldstein, Martin Z.....13345 W. McNichols Rd., Detroit 35
Fellner, Wm. A.....3202 Gen. Motors Bldg., Detroit 2
Fellows, William R.....22161 W. Outer Dr., Dearborn
Fenech, Harold B.....324 Professional Bldg., Detroit 1
Fenner, Wm. G.....12454 E. Outer Dr., Detroit 24
Fennessey, John F.....512 Rivard, Grosse Pte. 30
Fenton, Edwin H.....15125 Grand River Ave., Detroit 27
Fenton, Meryl M.....8600 W. McNichols Rd., Detroit 21
Fenton, Russell F.....15125 Grand River Ave., Detroit 27
Fenton, Stanley C.....15618 E. Warren, Detroit 24
Fentress, Vance.....641 David Whitney, Detroit 26
Feringa, Philip J.....20901 Moross Rd., Detroit 36
Ferrara, Richard J.....20045 Mack Ave., Grosse Pte. Woods
Ferrara, Virginia M.....18422 Woodward, Detroit 3
Ferris, George N.....20001 Greenfield, Detroit 35
Ferszt, Marion S.....18019 Rutherford, Detroit 35
Figiel, Leo S.....719 Berkshire, Grosse Pte 30
Figiel, Steven J.....4160 John R. St., Detroit 1
Filkin, Lawrence E.....621 Fairbrook, Northville
Fill, Leon.....987 E. Jefferson, Detroit 7
Finch, Alvis D.....18000 Jas. Couzens Hwy., Detroit 35
Finch F. Sinclair.....894 N. Renaud, Detroit 36
Finck, Jerome H.....25841 Plymouth, Detroit 39
Fine, Edward.....1112 Kales Bldg., Detroit 26
Fine, Gerald.....Henry Ford Hosp., Detroit 2
Fink, Saml.....10161 Burton, Oak Park
Finkell, Lawrence J.....15231 W. 7 Mile Rd., Detroit 35
Finkelstein, Lionel..15800 W. McNichols Rd., Detroit 27
Finkelstein, M. B.....18254 Livernois, Detroit 21
Firnschild, Paul G. (A).....2934 Biddle, Wyandotte
Fischer, Fredk. J.....654 Fisher Bldg., Detroit
Fischhoff, Jos.....18674 Fairfield, Detroit 21
Fishbein, Herbert L.....987 E. Jefferson Ave., Detroit 7
Fisher, Geo. S.....1709 Dav. Whitney Bldg., Detroit 26
Fisher, James M.....176 Merriweather, Grosse Pte. 36
Fisher, Ralph L.....8445 E. Jefferson Ave., Detroit 14
Fitzgerald, C. H.....Wayne Co. Gen. Hospital, Eloise
Fitzgerald, James M.....15801 W. McNichols, Detroit 35
Fitzpatrick, F. W.....17187 Schaefer, Detroit 35
Flaherty, Henry J...19600 W. McNichols Rd., Detroit 19
Flaherty, Norman W.....24315 Fairmont Dr., Dearborn
Flake, Thomas M.....5050 Joy Rd., Detroit 4
Fleming, Jos. L.....4218 Wendell Rd., Orchard Lake
Flora, Wm. R.....8100 E. Jefferson Ave., Detroit 14
Flower, James A. (R).....14140 Puritan Ave., Detroit 27
Floyd, William S.....19105 W. 7 Mile Rd., Detroit 19
Fogt, Herbert E. (L).....11801 Morang Dr., Detroit 24
Fogt, Robt. G.....11801 Morang Dr., Detroit 24
Foley, Hugh S. (L)..22255 W. Michigan Ave., Dearborn
Foote, John A.....1336 Southfield Rd., Lincoln Park
Ford, Geo. A. (L).....28 W. Adams Ave., Detroit 26
Fordell, Frank S.
Forgrave, Edward G.....18520 Grand River, Detroit 23
Fosnaugh, Robert P.....23185 Timberline, Southfield
Foster, E. Bruce.....852 Fisher Bldg., Detroit 2
Foster, Owen C. (L)....1553 Woodward Ave., Detroit 26
Foster, Wallace M.....13700 Woodward Ave., Highland Park 3
Fowler, Melvin E.....247 E. Warren St., Detroit 1
Fraiberg, Paul L.....13001 W. Chicago Blvd., Detroit 28
Frame, Boy.....18694 Warrington Dr., Detroit 21
France, Chas. J.....838 Berkshire Rd., Grosse Pointe 30
Franjac, Marion J.....25447 Plymouth Rd., Detroit 39
Franklin, John E.....4075 Ink Rd., Inkster
Franzen, Nils A.....19566 W. Grand River, Detroit 23
Frazer, Mary M. (L).....748 Seminole, Detroit 14
Frederickson, Geo. C.....7430 Second, Detroit 2
Free, Harry W.....14300 W. McNichols, Detroit 35
Freedman, Arthur M.....7701 Wyoming, Dearborn
Freedman, John.....4853 Second Blvd., Detroit 1
Freedman, Milton....18626 Santa Barbara Dr., Detroit 21
Freeman, Donald K.....881 Chalmers St., Detroit 15
Freeman, Mable.....1316 Dav. Broderick Twr. Detroit 26
Freeman, Michael W.....1810 Wellesley Dr., Detroit 3
Freeman, Wilmer.....940 East 7 Mile Rd., Detroit 3
Freid, Samuel.....17537 Parkside, Detroit 21
Freier, Andrew A.....1151 Taylor, Detroit 2
Freier, Morton L.....13051 Puritan Ave., Detroit 27
Freilich, Olga.....Detroit Mem. Hosp., Detroit 36
Freitas, Eugene L.....St. Johns Hospital, Detroit 36
Fremont, J. Courtney.....1202-4 David Wht. Bldg., Detroit 26
Frenkel, Eugene P. (A).....University Hosp., Ann Arbor
Frey, James L.....1553 Woodward Ave., Detroit 26
Friedlaender, Alex S.....10300 W. 7 Mile Rd., Detroit 21
Friedlaender, Sidney.....10300 W. 7 Mile Rd., Detroit 21
Friedlander, Joseph.....7411 Third, Detroit 2
Friedman, David.....2429 E. Milwaukee Ave., Detroit 11
Friedman, Isidor H.....3773 2nd Ave., Detroit 1
Friedman, Seymour.....5132 Allen Rd., Allen Park
Fritz, George E.....22101 Moross Rd., Detroit 36
Frost, Harold M.....Henry Ford Hosp., Detroit 2
Frost, Richard G.....1800 Tuxedo, Detroit 6
Fryfogle, James D.....C.D. 8, Med. Concourse, Northland Center, Southfield
Fulgenzi, William R.....1305 Kales Building, Detroit 26
Fuller, Hugh M.....1257 Dav. Whitney Bldg., Detroit 26
Fulton, Wm. J. (R).....Wye Ferry, Queenstown, Md.

Gaffney, J. Mitchell.....13600 Ohio, Detroit 21
Gagliardi, Carl A.....3516 Fort St., Lincoln Park
Gahagan, Thomas.....Henry Ford Hosp., Detroit 2
Gajewski, John E.....Parke Davis and Co., Detroit 32
Galantowicz, H. C.....7433 Mich. Ave., Detroit, 10
Galantowicz, Thos. H.....20217 Ann Arbor Trail, Dearborn

Galdonyi, Laslo (L).....2311 Dav. Broderick Twr., Detroit 26
Galdonyi, Nicholas (L).....8001 W. Jefferson Ave., Detroit 17
Galerneau, Darrel B. (L).....7394 Engleman, Centerline
Gall, Henry.....275 W. Grand Blvd., Detroit 16
Gallant, Vincent J.....53 Chicago Bldg., Detroit 2
Ganos, Thos.....6742 Park Ave., Allen Park
Gans, Robert I.....7310 W. 7 Mile Rd., Detroit 21
Ganschow, John H.....1840 Holbrook Ave., Detroit 12
Gardner, Lawrence W.....6071 W. Outer Dr., Detroit 35
Gardner, Max L.....19557 Mack Ave., Grosse Pointe
Gariepy, Louis B.....16401 Grand River St., Detroit 27
Gariepy, Louis J. (L).....16401 Grand River, Detroit 27
Gass, H. Harvey.....958 Fisher Bldg., Detroit 2
Gaston, Herbert B.....7501 W. Morrow Circle, Dearborn
Gates, Nathaniel (L)....516 Professional Bldg., Detroit 1
Gaynor, Alex.....1755 E. 7 Mile Rd, Detroit 3
Gehring, Harold W.....20211 Greenfield, Detroit 35
Geib, Ledru O. (L).....3528 Van Dyke Ave., Detroit 14
Geitz, Wm. A. (R).....Box 1133, Boca Raton, Fla.
Gelbach, Philip D.....2900 S. Fort St., Detroit 17
Gemeroy, Jos. C.....962 Fisher Bldg., Detroit 2
Gerisch, Robt. A.....1217 Dav. Whitney Bldg., Detroit 26
Gerondale, Elmond J.....3001 W. Grand Blvd., Detroit 2
Gibson, Dunbar P.....Box 1256, Detroit 31
Gibson, Wm.....7440 Mack Ave., Detroit 14
Giese, Fred W.....18526 Schoolcraft, Detroit 23
Gigante, Nicola.....10 Peterboro, Detroit 1
Gigliotti, David.....2500 W. Grand Blvd., Detroit 8
Gilbert, Harold R.....13146 Phelps, Wyandotte
Gillespie, Stephen M.....23100 Cherry Hill, Dearborn
Gilpin, Watson A.....1539 Lockridge, Bloomfield Hills
Gilreath, James L.....1800 Tuxedo, Detroit 6
Gilroy, John.....Harper Hosp., Detroit
Gimbel, Nicholas S.....1800 Tuxedo, Detroit 6
Ginsberg, Harold I.....15344 McNichols Rd., Detroit 35
Gitlin, Chas.....2424 Oakman Blvd., Detroit 35
Gittins, Perry C.....20905 Greenfield Rd., Southfield
Givens, Donovan H.....3453 Charlevoix Ave., Detroit 7
Gizynski, Waldemar E.....15400 Edington Rd., Livonia
Glasgow, Gordon K...1174 3 Mile Rd., Grosse Pointe 30
Glassman Saml. (L).....9233 Emerson Surf Side, Miami Beach, Fla.
Glazer, Walter S.....1490 Charrington Rd., Birmingham
Glees, John L.....P.O. Box 1318, Detroit
Glemet, Raymond B. (L).....216 W. Grand Blvd., Detroit 16
Glikman, Victor.....20131 James Couzens, Detroit 35
Glowacki, Ben F.....8 Mile & Greenfield, Southfield
Glowacki, Edward T.....719 New Center Bldg., Detroit 2
Godley, Alegro J.....18060 Conant St., Detroit 34
Goerke, Elmer A.....36663 Goddard Rd., Romulus
Goetz, Angus G.....1553 Woodward Ave., Detroit 26
Goins, Wm. F.....6675 Tireman, Detroit 4
Goldberg, Arthur.....340 E 8 Mile Rd., Detroit 3
Goldberg, Harry H. (L).....2211 Woodward Ave., Detroit 1
Goldberg, Nathan H. (L).....2211 Woodward Ave., Detroit 1
Golden, Alfred.....26764 York Rd., Huntington Woods
Goldfaden, Alfred.....6658 W. Fort St., Detroit 9
Goldman, Aubrey.....17191 James Couzens, Detroit 35
Goldman, Leonard....8830 W. McNichols Rd., Detroit 21
Goldman, Perry.....16805 Princeton, Detroit 21
Goldrath, Milton H.....17000 W. 8 Mile Rd., Southfield
Goldstein, Abe S.....18450 North Lawn, Detroit 21
Goldstein, Sidney (A)..Northville State Hosp., Northville
Gollman, Maurice D.....17000 W. 8 Mile Rd., Southfield
Gomez, Manuel R.....5224 St. Antoine St., Detroit 2
Gomley, Romuald H.....7220 Gratiot Ave., Detroit 13
Goodman, Maxwell M.....22265 Garrison, Dearborn
Goodman, Virgil P.....762 Bedford Rd., Grosse Pte. Pk.
Goodwin, Warren W.....20131 James Couzens, Detroit 35
Goodwin, William P.....3806 Pasadena, Detroit 38
Gordon, John W. (R)....12700 Mendota Ave., Detroit 38
Gordon, Wm. E.....18058 Greenfield, Detroit 35
Gorelick, Martin J.....23901 Michigan Ave., Dearborn
Gorning, Raymond P.....857 Marlborough Ave., Detroit 15
Goryl, Stephen V.....21501 Kelly, East Detroit
Goss, Saml. B.....10 Peterboro, Detroit 1
Gotham, James E.....3825 Brush St., Detroit 1
Gottlieb, Jacques S.....951 E. Lafayette, Detroit 7
Gottschalk, Fred W. (L).....712 Kales Bldg., Detroit 26
Gould, Sylvester E.....Wayne Co. Gen. Hosp., Eloise
Goux, Raymond S. (L).....545 David Whitney Bldg., Detroit 26
Grabiel, Amado.....10151 Michigan, Dearborn
Grace, Jos. M.....27453 Rainbow Circle, Lathrup Village
Grady, Jos. A.....946 3 Mile Dr., Detroit 30
Grafflin, Allan L.....Henry Ford Hosp., Detroit 2
Graham, John G., Jr...491 Lincoln Rd., Grosse Pointe 30
Granger, Francis L.....14160 Gratiot Ave., Detroit 5
Granger, George R...705 Dav. Whitney Bldg., Detroit 26
Grant, Abraham H.....18024 Sorrento, Detroit 35
Grant, Heman E. (L).....Lewiston
Gratton, Henri L. (L).....76 W. Adams Ave., Detroit 26
Graves, James H.....861 Fisher Bldg., Detroit 2
Gray, Howard O.....5050 Joy Rd., Detroit
Greek, Louis M.....12901 E. McNichols, Detroit 5
Green, Edward W.....2799 W. Grand Blvd., Detroit 2
Green, Ellis R. (L).....5172 Scotten Ave., Detroit 10
Green, Henry L. (M).....15540 Killarney St., Howard Beach, New York, N.Y.
Green, Lewis.....13000 Grand River, Detroit 27
Green, Louis M.....14636 E. 7 Mile Rd., Detroit 5
Green, Milton M.....1180 Southfield Plaza, Southfield
Green, Nelson W.....15800 W. McNichols, Detroit 35
Green, Thomas, Jr.....5050 Joy Rd., Detroit 4
Greenberg, Jack R.....15743 W. 7 Mile Rd., Detroit 35
Greenberg, Julius J.....5238 W. Outer Drive, Detroit 35
Greenberg, Morris Z.....9105 Van Dyke, Detroit 13
Greenberg, Stanley.....660 Maccabees Bldg., Detroit 2
Greene, John B.....2179 W. Grand Blvd., Detroit 8
Greenidge, Robt. I. (L).....4839 Beaubien, Detroit 1
Greerlee, Wm. T.....15053 Maddelein, Detroit 5
Greenslit, Frank S.....U.S. Vets. Admin. Hosp., Dearborn
Gregory, Louis J.....47 Webber Place, Detroit 36
Greifenstein, F. E.....1401 Rivard, Detroit 7
Greiner, Bert A.....14607 E. 7 Mile Rd., Detroit 5
Grekin, John N.....7421 W. 7 Mile Rd., Detroit 21
Grier, William H.....901 Industrial Bldg., Detroit 26
Griffin, Robert J.....17401 Mack Ave., Detroit 24
Griffiths, Sydney J.....15400 Plymouth Rd., Detroit 27
Grimaldi, Gregory J. (A).....2983 Seminole, Detroit 14
Grinstein, Alexander.....18466 Wildemere, Detroit 21
Grishkoff, M. A.....2201 E. Jefferson, Detroit 7
Griva-Lizlovs, S.....29901 Ford Rd., Garden City
Grob, Otto.....7385 Parkstone Lane, Birmingham
Gronemeyer, Wm. H.....1800 Tuxedo, Detroit 6
Gross, Louis.....18937 Van Dyke St., Detroit 34
Grossman, Solomon C.....538 Maccabees Bldg., Detroit 2
Guerrero, Jose (L).....13700 Woodward, Detroit 3
Guidot, Julian M.....13345 W. McNichols, Detroit 35
Guimaraes, Abilio S. (L)..7301 Schaffer Hwy., Dearborn
Guinan, Geo. E.....27614 Gainsborough, Inkster
Guindi, Sami F.....1080 Fisher Bldg., Detroit 2
Gulick, Arthur E.....4160 John R, Detroit 1
Gurdjian, Elisha S.....1553 Woodward Ave., Detroit 26
Gurri, Jose P.....No. Det. General Hosp., Detroit 12
Gurskis, Eugenia E.....504 Kales Bldg., Detroit 26
Gustafson, David C.....1 Lafayette Plaisance, Detroit 7
Gutov, Benjamin R.....7441 W. 7 Mile Rd., Detroit 21
Guyton, Jack S.....2799 W. Grand Blvd., Detroit 2

Hacker, Elaine M.....293 Merriweather Rd., Grosse Pte. Farms
Hackert, John L.....14551 Southfield Rd., Allen Park
Haddad, Benjamin F.....1010 Mich. Mutual Bldg., Detroit 26
Haddad, Elias D.....9191 Whittier, Detroit 24
Hadesman, Donald.....985 E. Jefferson, Detroit 7
Haefele, Leslie P.....29108 Ford Rd., Garden City
Hagermoser, H. H. (A).....5991 Yorkshire, Detroit 24

Hagge, Donald R.....29594 W. 5 Mile Rd., Livonia
Hahne, Otto H.....Herman Kiefer Hosp., Detroit 2
Haidostian, B. H.....18456 Grand River, Detroit 23
Haitinger, K. S.....22175 Thorofare, Grosse Isle
Haking, Leonard.....14014 E. 7 Mile Rd., Detroit 5
Halekas, G. Peter.....21727 Mack Ave., St. Clair Shores
Hall, Arch H.....10 Peterboro, Detroit 1
Hall, E. Walter (L).....14189 Rosemont Rd., Detroit 23
Hall, Ralph E.....10 Peterboro St., Detroit 1
Hall, Robt. J. (L).....6014 W. Fort St., Detroit 9
Hall, Winthrop D.....5237 Oakman Blvd., Dearborn
Hallen, Leonard J.....1335 Nicolet Pl., Detroit 7
Halsted, James A.....V.A. Hospital, Dearborn
Hamburg, Robt. H.....1515 Dav. Whitney Bldg., Detroit
Hamburger, Albert C.....13345 W. McNichols, Detroit
Hamburger, Joel I...15121 W. McNichols Rd., Detroit 35
Hamburger, Stuart W...18400 Schaefer Hwy., Detroit 35
Hamil, Brenton M.....Henry Ford Hosp., Detroit 2
Hamilton, Norman C...300 W. McNichols Rd., Detroit 3
Hamilton, Quentin P.....20905 Greenfield, Southfield
Hammer, Edwin J.....16616 Mack Ave., Detroit 24
Hammer, Roy W.....11455 E. McNichols, Detroit 35
Hammond, Arthur E.....1553 Woodward Ave., Detroit 26
Hammond, James L. (L).....1911 Sunset Dr., Escondido, Calif.
Handel, Jack E.....1800 Tuxedo, Detroit 6
Hank, Emil J.....32316 Grand River, Farmington
Hansen, Fredk. E. (L).....18160 Birwood, W. Beverly Hills, Birmingham
Hansen, John W. (A).....8877 Perrin Dr., Livonia
Hanyi, Karl.....7645 Thornwood, Plymouth
Hardstaff, R. John (L).....648 Neff Rd., Grosse Pte. 30
Hardt, Barbara A. (A).....15867 Mansfield, Detroit 27
Hardy, Clarence M.....23019 Ecorse Rd., Taylor
Hardy, Geraldine M.....18145 Mack, Detroit 24
Hardy, Warren G.....801 Dav. Whitney Bldg., Detroit 26
Harelik, Ely W.....Det. House Correction, Plymouth
Harkaway, Roman W.....19125 Van Dyke, Detroit 34
Harley, Garth H.....300 Hampshire, Dearborn
Harley, Louis M.....4100 W. McNichols Rd., Detroit 21
Harm, Winfred B.....16260 Cherrylawn Ave., Detroit 21
Harmon, Edwin L.....441 E. Jefferson, Detroit 26
Harmon, Walter, Jr.....2510 E. Davison, Detroit 12
Harper, Jesse T.....1252 Dav. Whitney Bldg., Detroit 26
Harrell, Voss.....1035 Oakwood Ave., Dearborn 7
Harrington, F. L.....14341 W. McNichols, Detroit 35
Harris, A. D.....12815 Linwood, Detroit 38
Harris, Harcourt G.....9141 Dexter Blvd., Detroit 6
Harris, Harold H.....8011 W. Vernor Highway, Detroit 9
Harris, Ivor D.....1245 Dav. Whitney Bldg., Detroit 26
Hart, Charles E.....23845 Van Dyke, Centerline
Hart, John C.....9341 Moffat, Detroit 13
Hartkop, Henry H.....20055 Mack Ave., Detroit 36
Hartquist, Robt. J.....1495 Fort St., Wyandotte
Hartzell, John B.....7815 Jefferson Ave. E., Detroit 14
Hasley, Clyde K. (L).....2320 N. LaSalle Gardens, Detroit 6
Hassett, Gerard R.....St. Marys Hospital, Livonia
Hassig, Walter W.....20914 Kelly, East Detroit
Hastings, Orville J.....15744 Harper Ave., Detroit 24
Haszczyc, Vladimir A.....2730 E. Jefferson, Detroit 7
Hathaway, Hubert R.....230 Madison Ave., Detroit 26
Haubrich, Wm. S.....Henry Ford Hosp., Detroit 2
Hause, Glen E.....18520 Grand River, Detroit 23
Hauser, I. Jerome.....7411 Third Ave., Detroit 2
Hauser, John E.....671 Fisher Bldg., Detroit 2
Hauser, Maurice J. (A).....7411 Third Ave., Detroit 2
Hauss, Robert B.....7348 Kercheval, Detroit 14
Havers, Howard (L).....271 Kenwood Ct., Detroit 36
Hawkins, James W. (L).....388 Prudence, Sarasota, Fla.
Hayes, Dean M.....713 Dav. Whitney Bldg., Detroit 26
Hazen, Roy S.....20526 Grand River Ave., Detroit 19
Heath, Leonard P.....1553 Woodward Ave., Detroit 26
Heavner, Lyle E.....119 Kercheval, Grosse Pointe 36
Hecht, Manes S.....25717 Coolidge, Oak Park 37
Heenan, Theophilus H.....1553 Woodward Ave., Detroit 26
Heideman, Louis E.....20211 Greenfield Rd., Detroit 35
Heins, Marilyn.....747 Lakeland, Grosse Pointe 30
Heldt, Richard F.....1951 Monroe Blvd., Dearborn
Heldt, Thos. J. (L).....2799 W. Grand Blvd., Detroit 2
Hendelman, Manuel H.....17141 Hayes, Detroit 5
Henderson, Allison B.....9041 Dexter Blvd., Detroit 6
Henderson, Arthur B. (L)..10452 Mack Ave., Detroit 14
Henderson, Chas. W.....3011 W. Grand Blvd., Detroit 2
Henderson, Frederic C.....18101 E. Warren, Detroit 24
Henderson Harold (L)....3011 W. Grand Blvd., Detroit 2
Henderson, Hugh W.....18101 E. Warren, Detroit 24
Henderson, Leslie T. (L)....14814 E. Warren, Detroit 15
Henderson, Wm. E. (L).....9341 Chalmers, Detroit 13
Henig, Fred N.....7605 W. 7 Mile Rd., Detroit 21
Henkin, Raymond.....17228 Shervilla, Southfield
Henkin, Wm. A.....18215 Greenfield, Detroit 35
Henrich, Laurence E.....2501 W. Grand Blvd., Detroit 8
Henry, Robert C.....16127 Baylis, Detroit 21
Herbst, Harold B.....20482 Ardmore, Detroit 35
Hergt, Klaus.....30320 Pondsview Dr., Franklin
Herrold, Rose E.....1277 E. Grand Blvd., Detroit 11
Herschelmann, Roy F.....3343 Gratiot Ave., Detroit 7
Hertzler, Jack H.....3011 W. Grand Blvd., Detroit 2
Herwick, John T.....2799 W. Grand Blvd., Detroit 2
Hess, Joseph W.....Harper Hospital, Detroit 1
Hess, Murray W.....23860 Seneca, Oak Park 37
Heyman, Louis F.....19009 W. 7 Mile Rd., Detroit 19
Heyner, C. S.....3424 Oakman Blvd., Detroit 4
Heyner, Stanley A.....3424 Oakman Blvd., Detroit 4
Hickey, Joe.....23100 Cherry Hill, Dearborn
Hicks, Fredk. G.....1000 Westwood, Birmingham
Hildner, Frank J. (A).....16840 Monica, Detroit 21
Hill, Edward J., Jr...208 Dav. Whitney Bldg., Detroit 26
Hill, Raymond D.....14551 Southfield, Allen Park
Hillenberg, Sidney J.....19350 W. 7 Mile Rd., Detroit 19
Hiller, Glenn I.....13700 Woodward Ave., Detroit 3
Hillier, Leland G.....18750 Woodward Ave., Detroit 3
Hillyer, John W.....26151 Huron River Dr., Flat Rock
Hilton, Wm. E.....5013 Harding, Detroit 13
Himmelhoch, A. J.....19220 Kingston Rd., Detroit
Hinchman, D. F.....27459 5 Mile Rd., Livonia
Hipps, Chauncey J.....2605 West Grand Blvd., Detroit 8
Hirsch, Leo J.....15800 W. McNichols, Detroit 35
Hirsch, Lore.....212 S. Melborn, Dearborn
Hirschfeld, A. H.....829 Fisher Bldg., Detroit 2
Hirschman, Louis J. (L).....2619 Munson Ave., Traverse City
Hoagland, F. L. (A).....716 E. Grand Blvd., Detroit 7
Hobbs, Donald V.....27305 Southfield Rd., Lathrup Village
Hochman, Morton M.....16633 Plymouth Rd., Detroit 27
Hodges, Jason.....26401 Harper, St. Clair Shores
Hodgkinson, Chas. P.....17546 Meadwood Ave., Lathrup Village
Hoffer, Thos.....5825 Allen Rd., Allen Park
Hoffman, Ben G.....19545 Shrewsbury, Detroit 21
Hoffman, Edward A.....7615 W. Vernor Hwy., Detroit 9
Hoffman, Edwin S. (R).....8106 E. Jefferson Ave., Detroit 14
Hoffman, Harry Y.....15085 E. 7 Mile Rd., Detroit 5
Hoffman, Henry A.....10015 E. Outer Dr., Detroit 24
Hoffman, Louis.....18203 Birchcrest Dr., Detroit 21
Hoffman, Milton C.....18555 E. Warren, Detroit 36
Hoffmann, Martin H.....1311 David Whitney Bldg., Detroit 26
Hogikyan, Azat.....16901 W. McNichols Rd., Detroit 35
Holdredge, Jean M.....3011 W. Grand Blvd., Detroit 2
Hollander, Abraham J.....14327 Michigan Ave., Dearborn 2
Hollinger, F. Wayne....8265 Gen. Mtrs. Bldg., Detroit 2
Hollis, Henry B.....6809 Sirena, Detroit 10
Holloway, Janet L.....7430 Second, Detroit 2
Holmes, Geo. F.....14729 Champaign, Allen Park
Holstein, Arthur P.....875 Balfour, Grosse Pte. 30
Holt, Chas. J., Jr.....1575 Faircourt, Grosse Pointe 36
Holt, Henry T.....5050 Cass St., Detroit 2
Homeister, Eugene A.....12925 Pennsylvania Ave., Wyandotte

Honhart, Fred L. (L).....1405 Berkshire Road, Grosse Pointe 30
Hooker, Lyle T.....35519 Norris St., Wayne
Hoops, Geo. B. (L)....18415 Warrington Dr., Detroit 21
Hopkins, Andrew J.....10149 Michigan Ave., Dearborn
Hopkins, Scovell M.....910 Dav. Broderick Twr., Detroit
Horkins, Earl J.....10963 Farmington Rd., Livonia
Horn, Robt. C.....2799 W. Grand Blvd., Detroit 2
Hornbeck, Robert J.....33563 W. 5 Mile Rd., Livonia
Horny, Hugo O.....619 Barrington Rd., Detroit 30
Horton, Reece H.....1553 Woodward Ave., Detroit 26
Horvath, James J.....1553 Woodward Ave., Detroit 26
Horvitz, Victor S.....18400 Schaefer Hwy., Detroit 35
Hoski, A. Joseph.....3919 John R. St., Detroit
Hotchkiss, Loris M.....33220 W. 7 Mile Rd., Livonia
Howard, Philip J.....Henry Ford Hosp., Detroit 2
Howard, William K.....1800 Tuxedo, Detroit 6
Howell, Bert F.....10800 Whittier Rd., Detroit 24
Howell, James T.....2799 W. Grand Blvd., Detroit 2
Howes, Homer A.....1515 Dav. Whitney Bldg., Detroit 26
Howlett, Howard T.....868 Fisher Bldg., Detroit 2
Hoyos, Pedro G.....1401 Rivard St., Detroit 7
Hromadko, Louis.....1053 Fisher Bldg., Detroit 2
Hubbard, John P., Jr.....14620 E. 7 Mile Rd., Detroit 5
Huber, Philip J.....1724 Bassett, Royal Oak
Hudson, J. Stewart (L).....17443 E. Jefferson Ave., Grosse Pointe 30
Hudson, Wm. A. (L).....502 S. Pine St., Harrison, Ark.
Hudspeth, E. Rae.....753 Fisher Bldg., Detroit 2
Huegli, Wilfred A.....16840 E. Warren Ave., Detroit 24
Huggins, H. Horne.....8355 Gratiot, Detroit 13
Hulick, Archie G.....15525 Amherst Rd., Birmingham
Hull, Leroy W. (L).....6364 Cowell Rd., Brighton
Hume, H. Ross, Jr.....1553 Woodward, Detroit 26
Huminski, Thaddeus S.....19244 Van Dyke Ave., Detroit 34
Hummel, Arthur R.....1020 3 Mile Dr., Grosse Pointe 30
Hunt, Theodore H.....19431 Van Dyke Ave., Detroit 34
Hunt, Verne G.....1553 Woodward Ave., Detroit 26
Hunter, Donald G.....3245 E. Jefferson, Detroit 17
Hunter, Robert B.....Henry Ford Hosp., Detroit 2
Husband, Chas. W. (L).....14500 W. McNichols, Detroit
Husband, Raymond C...14500 W. McNichols, Detroit 35
Hutchins, M. Colton.....3011 W. Grand Blvd., Detroit 2
Hyatt, Jarvis M.....22340 Michigan Ave., Dearborn
Hyde, Fredk. W., Jr.....Grace Hospital, Detroit 1
Hyland, John R.....17200 Mack, Detroit 24
Hysni, Aliqemal.....8031 W. Vernor Hwy., Detroit 9
Iacobell, Peter H.....19300 Van Dyke, Detroit 34
Ice, Garnet T.....18060 Conant, Detroit 34
Iglesias, Luis J.....20211 Greenfield, Detroit 35
Igna, Eli J.....2799 W. Grand Blvd., Detroit 2
Ignagni, Antonio.....275 W. Grand Blvd., Detroit 16
Ine, Myung Yul.....1800 Tuxedo, Detroit 6
Irvin, Earle A.....Ford Motor Co., American Rd., Dearborn
Irwin, Wm. A.....2500 W. Grand Blvd., Detroit 8
Isaacson, Arthur (L).....250 E. Columbia, Detroit 1
Isaacson, Harold E.....15361 Plymouth Rd., Detroit
Isaacson, Jo D.....26008 Pembroke, Huntington Woods
Israel, Barney B.....5057 Woodward Ave., Detroit 2
Israel, Kenneth.....10607 W. 7 Mile Rd., Detroit 21
Itkin, H. David.....1800 Tuxedo, Detroit 6
Iwata, Herbert T.....7611 Patton Ave., Detroit 28
Izner, Sanford M.....17500 Schaefer Hwy., Detroit 35
Jacknow, David.....60 W. Hancock, Detroit 1
Jackson, Winston B.....2425 Oakman, Detroit 38
Jacobs, Howard.....18241 Greenfield, Detroit 35
Jacobson, Lyle F.....5224 St. Antoine, Detroit 2
Jacobson, Saml. D.....Wayne Co. Genl. Hosp., Eloise
Jacobus, Wayne N.....20055 Mack Ave., Grosse Pte. 36
Jaeger, Grove A.....11711 Minden, Detroit 5
Jaekel, Clarence N.....1086 E. Grand Blvd., Detroit 7
Jaffar, Donald J.....734 Maccabees Bldg., Detroit 2
Jaffe, Harold W...1706 David Whitney Bldg., Detroit 26
Jaffe, Jacob.....2211 Woodward Ave., Detroit 1
Jaffe, Julius L.....7463 Harper Ave., Detroit 13
Jaffe, Louis.....18662 Muirland, Detroit 21
Jahsman, Wm. E. (R)..1410 Sunset Dr., Clearwater, Fla.
Jakacki, Richard Wm.....36157 Sherwood, Livonia
Jakobovits, Thomas.....15361 Plymouth, Detroit 27
James, Thomas N.....Henry Ford Hosp., Detroit 2
Jamieson, Thos. J.....1310 Warwick, Lincoln Park
Janicki, Natalia J.....Eloise Hosp., Eloise
Jarkowski, T. L.....Harper Hospital., Detroit 1
Jarre, Hans A. (L).....Grace Hospital, Detroit 1
Jarvis, Harold F.....360 Moross, Detroit 36
Jasion, Lawrence J. (A).....11945 Payton, Detroit 24
Jaslow, Robt. I.....Plymouth St. Home & Trng. Sch., Northville
Jaynes, Richard V.....29901 Ford Rd., Garden City
Jeffries, Benj.....16321 Mack Ave., Detroit 24
Jend, Wm., Jr.....1365 Cass Ave., Detroit 26
Jend, Wm. J. (L).....12781 E. Outer Dr., Detroit 24
Jenkins, Elwood A.....1102 Dav. Whitney Bldg., Detroit 26
Jennings, Chas. G.....17700 Mack Ave., Detroit 24
Jensen, Viggo W.....532 Lincoln Rd., Detroit 30
Jentgen, Chas. J. (L).....22101 Moross Rd., Detroit 36
Jeremias, Robt. C.....17563 Greenfield, Detroit 35
Jevons, William H.....21309 River Rd., Grosse Pte. Wds.
Jewell, F. C.....159 Kercheval Ave., Detroit 36
Jewell, John S.....2021 Monroe, Suite 203, Dearborn
Jewell, Marvin R.....Children's Hospital, Detroit 2
Jocz, Marion W.....945 Trombley Rd., Detroit 30
Jodar, Emery O.....15760 Mack Ave., Detroit 24
Jodar, Loyal W.....18412 Mack, Grosse Pointe 36
John, Hubert R. (L).....20905 Greenfield, Southfield
Johnson, Aran S.....1462 Hollywood, Grosse Pte. Wds. 30
Johnson, Arthur J.....Henry Ford Hospital, Detroit 2
Johnson, Gage (A).....3395 Scranton, Cleveland, Ohio
Johnson, Homer L.....2799 W. Grand Blvd., Detroit 2
Johnson, Ralph A.....7815 E. Jefferson Ave., Detroit 14
Johnson, Simon O.....Cadillac Sq. Bldg., Detroit 26
Johnson, Thos. D.....20526 Grand River, Detroit 19
Johnson, Verne E.....2051 Monroe Ave., Dearborn
Johnson, Vernon P...21327 Harper Ave., St. Clair Shores
Johnson, Wilbur E.....14654 Gratiot, Detroit 5
Johnson, Wm. H. M.....7157-63 Michigan, Detroit 10
Johnston, Everett V.....30130 Bristol Lane, Birmingham
Johnston, Herbert C.....3001 Miller Rd., Dearborn
Johnston, John L. (A).....1950 W. McNichols Rd., Detroit 3
Johnston, Jos. A.....Henry Ford Hospital, Detroit 2
Johnston, Wm. E.....3011 W. Grand Blvd., Detroit 2
Johnstone, Benj. I.....555 Fisher Bldg., Detroit 2
Joinville, Euclide V. (L)....1202 Stroh Bldg., Detroit 26
Jones, Adrian R.....15309 Mack Ave., Detroit 24
Jones, Arnold M.....3706 Sturtevant, Detroit 6
Jones, G. Richard.....18412 Mack Ave., Detroit 36
Jones, Roy D.....10234 Puritan Ave., Detroit 38
Jones, Wm. J.....8209 Allen Rd., Allen Park
Joos, Thad H.....20867 Mack, Grosse Pte. Woods
Jordan, Prescott, Jr.....5224 St. Antoine, Detroit 2
Jordan, R. Gerald.....12410 Van Dyke, Detroit 34
Joseph, Ramon R.....Wayne Co. Gen. Hospital, Eloise
Joyce, Stanley J.....1078 Fisher Bldg., Detroit 2
Jovrich, Myron H.....Sinai Hospital, Detroit 35
Juliar, Benj.....17305 Muirland Ave., Detroit 21
Jungwirth, R. V.....19350 W. McNichols Rd., Detroit 19
Kackley, James E.....18495 Mack Ave., Detroit 36
Kadian, George.....15201 W. McNichols Rd., Detroit
Kaine, Henry D.....3011 W. Grand Blvd., Detroit 2
Kalayjian, Bernard S...30676 Harlincin Ct., Birmingham
Kalichman, Nathan.....18440 Livernois, Detroit 21
Kallenbach, Rudolf W.....388 Inkster Rd., Inkster
Kallet, Herbert I.....651 Fisher Bldg., Detroit 2
Kallet, Maerit B.....1800 Tuxedo, Detroit 6
Kallman, David.....2351 W. Grand Blvd., Detroit 8
Kallman, Leo.....2351 W. Grand Blvd., Detroit 8
Kallman, Reuben R.....2631 Woodward Ave., Detroit 1
Kamil, Richard S.....14438 McNichols, Detroit 35
Kaminski, Zeno L. (L).....3510 24th St., Detroit 8
Kane, Archibald V.....2500 W. Grand Blvd., Detroit 8
Kansa, Selma.....19431 Van Dyke, Detroit 34
Kanter, Herman (A)....13127 W. 7 Mile Rd., Detroit 35

Kapetansky, A. J.....1728 Clairmount, Detroit 6
Kapetansky, Don I.....18400 Schaefer, Detroit 35
Kapetansky, Nathan J.....1728 Clairmount, Detroit 6
Kaplita, Walter A...60 Fontana Lane, Grosse Pte. Shores
Karamatas, Philip C.....13244 W. Warren, Dearborn
Karch, Saul.....18080 Muirland, Detroit 21
Kasabach, Harry Y.....1553 Woodward Ave., Detroit 26
Kasabach, Vahram Y.....1814 Book Tower, Detroit 26
Kashtan, Harry A.....17300 Schaefer, Detroit 35
Kasper, Jos. A.....19953 Clairview Ct., Detroit 36
Kaspor, Albert J.....20901 Moross Rd., Detroit 36
Kass, Arnold.....1316 David Stott Bldg., Detroit 26
Katz, Lawrence.....987 E. Jefferson, Detroit 7
Katz, Martin.....7300 Harding, Taylor
Katzman, Harold L.....412 Fox Bldg., Detroit 1
Katzman, Irving S.....412 Fox Bldg., Detroit 1
Kaufman, Jack H.....12901 W. 7 Mile Rd., Detroit 35
Kaufman, Louis W.....10326 W. 7 Mile Rd., Detroit 21
Kaufman, William H.....10149 Michigan Ave., Dearborn
Kauppinen, Jalo A.....15400 Plymouth Rd., Detroit 27
Kawchak, James.....Ford Motor Co., Dearborn
Kawecki, Lucian....10734 Hart Ave., Huntington Woods
Kawel, Conrad A., Jr.....27459 W. Warren, Garden City
Kazdan, Morris.....4619 Allen Rd., Allen Park
Keating, Thos. F. (L)....18675 Gainsborough, Detroit 23
Kehoe, Henry J.....15252 Gratiot Ave., Detroit 5
Keith, Kelly.....106 W. Davison Ave., Highland Park 3
Keith, Rachel H. C. B.....5353 Joy Rd., Detroit 4
Kelley, Frank J.....3919 John R St., Detroit 1
Kelly, A. P., Jr.....Henry Ford Hospital, Detroit 2
Kelly, John J.....14729 Champaign, Allen Park
Kelly, L. J.....14015 Gratiot, Detroit 5
Kelmenson, Victor A.....7356 Twelfth St., Detroit 6
Kelson, Malcolm J.....1045 Harvard, Detroit 30
Kemler, Walter J.....4045 W. Jefferson Ave., Ecorse 29
Kennary, James M.....4900 Cadieux Rd., Detroit 24
Kennary, James M., Jr.....4900 Cadieux Rd., Detroit 24
Kennedy, Chas. S. (L).....10 Peterboro St., Detroit 1
Kennedy, Donald J.....27030 Kingswood Dr., Dearborn
Kenning, John C. (A).....700 Avacado, Corona Delmar, Calif.
Kernick, Melvin O.....13700 Woodward Ave., Highland Park 3
Kernkamp, Ralph F.....10 Witherell, Detroit 26
Kerwin, George R.....Jennings Hospital, Detroit 14
Kerzman, Jos. H.....810 Kales Bldg., Detroit 26
Kessel, Karl J.....18031 Kelly Rd., Detroit 24
Kessler, Chas.....18241 Greenfield, Detroit 35
Keyes, John W.....Henry Ford Hospital, Detroit 2
Killins, Chas. G.....8100 E. Jefferson, Detroit 14
Kimberlin, K. K., Jr.....11110 Morang Dr., Detroit 24
King, Edward D. (L)....270 Rivard Blvd., Grosse Pte. 30
King, Melbourne J.....5435 W. Vernor Hwy., Detroit 9
King, Robert R.....261 Brady St., Detroit 1
Kingswood, Roy C.....1078 Fisher Bldg., Detroit 2
Kinsley, George.....15105 W. 7 Mile Rd., Detroit 35
Kitzmiller, John L.....15800 W. McNichols Ave., Detroit 35
Klaiber, Roger G.....25283 Colgate, Dearborn
Klein, Herman.....24030 Marlow St., Oak Park
Klein, Howard A...1846 David Whitney Bldg., Detroit 26
Klein, Sander P.....14825 W. McNichols Rd., Detroit 35
Klein, Wm.....13965 Linwood, Detroit 38
Kleinman, Shmarya (L).....1800 Tuxedo, Detroit 6
Kliger, David.....7756 Southfield, Detroit 28
Klimchuk, M. M.....22770 Kelly Rd., East Detroit
Kling, George A.....Harper Hospital, Detroit 1
Kling, Murray G.....18400 Schaefer Hwy., Detroit 35
Klosowski, Jos.....8222 E. Outer Dr., Detroit 13
Kluck, Clarence J.....25210 Grand River, Detroit 40
Klutke, Geo. H. E.....2841 Monroe, Dearborn
Knaggs, Earl J.....2387 Fort St., Wyandotte
Knapp, Floyd B. (R).....16565 Birwood, Detroit 27
Knapp, Gary H.....23611 Goddard, Taylor
Knapp, Gordon R. (R)....422 W. Goldengate, Detroit 3
Knapp, Wm. L.....20100 W. McNichols Rd., Detroit 19
Knights, Edwin M., Jr...2500 W. Grand Blvd., Detroit 8
Knoblauch, K. H.....952 Fisher Bldg., Detroit 2
Knobloch, Edmund J.....5933 Chene St., Detroit 11
Knox, Ross M.....3180 Fort St., Lincoln Park
Kobernick, Sidney D.....6767 W. Outer Dr., Detroit 35
Kobiljak, Stefan H.....3516 Fort St., Lincoln Park
Koebel, Raymond H.....640 Bedford Lane, Grosse Pte. 30
Kock, Hendrik J.....23100 Cherry Hill, Dearborn
Koerber, Edward J.....4876 Lakeview Ave., Detroit 15
Kogut, Constantine S.....10627 Puritan, Detroit 38
Kokowicz, Raymond J.....19440 Van Dyke, Detroit 34
Kolman, Isadore I.....1800 Tuxedo, Detroit 6
Komisaruk, Richard.....1025 E. Forest, Detroit 7
Kopmeyer, Joe M., Jr.....17632 Grandville, Detroit 19
Koran, Valentine L.....1306 Kales Bldg., Detroit 26
Koren, Louis.....1300 Cadillac Sq. Bldg., Detroit 26
Korum, Lyle W.....18585 E. Warren St., Detroit 36
Koschnitzke, H. K.....15101 Southfield, Allen Park
Kossayda, Adam W.....15324 Michigan Ave., Dearborn
Kovach, Emery P.....9750 Chalmers, Detroit 13
Kovan, Dennis D.....16965 Hamilton Ave., Highland Park 3
Kowaleski, John J.....12789 Veronica, Southgate
Kozlinski, Anthony E.....2195 E. Grand Blvd., Detroit 11
Krabbenhoft, K. L.....3825 Brush St., Detroit 1
Kraft, Ruth M.....19164 Devonshire Rd., Birmingham
Krakauer, Bernard..18424 W. McNichols Rd., Detroit 19
Krass, Edward W.....11088 Gratiot Ave., Detroit 13
Kraus, John J.....16840 E. Warren Ave., Detroit 24
Krawec, Charles J...Mt. Carmel Mercy Hosp., Detroit 35
Krebs, Wm. T.....16419 E. Warren Ave., Detroit 24
Kreinbring, Geo. E.....14295 E. 7 Mile Rd., Detroit 5
Kretzschmar, John C.....660 E. Grand Blvd., Detroit 7
Krevsky, David A.....8461 Park, Allen Park
Krevsky, Harold.....8461 Park Ave., Allen Park
Krieg, Earl G.....85 Kercheval Ave., Grosse Pte. Farms
Krieger, Harley L. (R).....11390 Strathmoor, Detroit 27
Krieger, Harvey.....954 Fisher Bldg., Detroit 2
Krieger, Ingeborg (A).....13112 Ladlow, Huntington Woods
Kritchman, Maurice J.....10 Witherell St., Detroit 26
Kroha, Lawrence A.....15124 Kercheval Ave., Detroit 30
Krohn, Lawrence H.....24340 W. McNichols Rd., , Detroit 19
Kroll, Harvey V.....7815 E. Jefferson, Detroit 14
Krynicki, Francis X.....15101 W. 7 Mile, Detroit 35
Krystal, Henry.....19210 Coyle, Detroit 35
Kubanek, Joseph L.....23134 Myrtle, Dearborn
Kuemierz, Francis S.....18934 Van Dyke Ave., Detroit 34
Kuehn, Ned N.....20243 Burgess Ave., Detroit 19
Kuhn, Albert A.....635 W. 7 Mile Rd., Detroit 3
Kuhn, Henry H.....635 W. 7 Mile Rd., Detroit 3
Kuhn, Richard F.....1700 Junction Ave., Detroit 9
Kujawski, Walter F.....16840 E. Warren, Detroit 24
Kulaski, Chester H.....9309 Joseph Campau Ave., Detroit 12
Kullman, Harold J.....Vet. Admin. Hosp., Dearborn
Kuran, Lionel V.....14853 Michigan, Dearborn
Kurcz, Jos. A.....7433 Michigan Ave., Detroit 10
Kurtz, Irvin J.....25210 Grand River, Detroit 40
Kurtzman, Raymond S...Detroit Mem. Hosp., Detroit 26
Kutsche, John D.....3794 Fort St., Trenton
Kvietys, Benj.....27235 Joy Rd., Dearborn
Kwasiborski, S. A.....2300 Oak St., Wyandotte
Laberge, James M.....100 Oak, Wyandotte
Lackey, Lawrence S.....525 Visger, Ecorse
Laderach, David C.....716 Marquette Dr., Detroit 14
La Ferte, Alfred D. (L).....520 St. Clair, Grosse Pte. 30
Laham, M. M.....2929 Fort St., Wyandotte
Lahood, Michael J.....20001 Greenfield, Detroit 35
Laige, Raymond J.....P.O. Box 1259, Detroit 31
Lakatos, George C.....33000 Palmer, Wayne
Lake, Robt. C.....8445 E. Jefferson, Detroit 14
Lakin, Alan C.....10326 W. 7 Mile Rd., Detroit 21
Lakin, Mervyn H.....17555 James Couzens, Detroit 35
Lakoff, Chas. B. (L)....10234 W. 7 Mile Rd., Detroit 21
Lam, Conrad R.....28130 Westbrook Ct., Farmington
Lamberson, Frank A.....19001 Grand River, Detroit 23
Lammy, James V...748 David Whitney Bldg., Detroit 26
Lamont, Richard L.....3815 Pelham Rd., Dearborn

Lanipman, Harold H.....3011 W. Grand Blvd., Detroit 2
Landers, James W.....1401 Rivard, Detroit 7
Landers, Maurice B.....275 W. Grand Blvd., Detroit 16
Lang, Ernst F.....Harper Hospital, Detroit 1
Lange, Wm. A.....1041 Cadieux Rd., Grosse Pte. 30
Langston, John D.....1420 St. Antoine St., Detroit 26
Laning, Geo. M. (L).....R.D. Morey Rd., Sharon, Conn.
Lansing, Eugene H.....33020 Palmer Rd., Wayne
Lansky, Mandell.....16339 E. Warren, Detroit 24
Large, Alfred M.....701 David Whitney Bldg., Detroit 26
Largo, Donald J.....16717 Warwick, Detroit 19
Larkin, Duane R.....28435 Plymouth. Livonia
Larned, Richard I.....15208 Bringard, Detroit 5
Larsen, Edward G.....1803 Trenton Dr., Trenton
Larsen, Robt. D.....76 W. Adams Ave., Detroit 26
Larson, Chas. J.....12729 Cunningham, Wyandotte
Larson, Francine S. (A)..18865 Haggerty Rd., Northville
Larsson, Bror H. (L).....3919 John R St., Detroit 1
Lasichak, Andrew G.....76 W. Adams Ave., Detroit 26
Lasley, James W...1014 David Whitney Bldg., Detroit 26
Latimer, Fredk. R.....28 W. Adams, Detroit 26
Latteier, Karl K.....968 Yarmouth, Birmingham
Lauppe, Edward H.....1553 Woodward Ave., Detroit 26
Lauppe, Fredk. A.....1553 Woodward Ave., Detroit 26
Laura, Albert L.....9105 Harrison, Livonia
Laurisin, Eugene (L).....16554 Muirland, Detroit 21
Lauter, Eric W.....1800 Tuxedo, Detroit 6
Lawhead, Nixon R. (L).....7348 Kercheval Ave., Detroit 14
Lawrence, Louis F.....17300 Schaefer Rd., Detroit 35
Lawson, James M.....2605 W. Grand Blvd., Detroit 8
Lawson, John W. (A).....98 Hazelwood Ave., Detroit 2
Lazar, Morton R.....7401 Third Ave., Detroit 2
Leach, David.....3011 W. Grand Blvd., Detroit 2
Leach, Robt. B.....1401 Rivard St., Detroit 7
Leacock, Robt. C.....440 University Pl., Grosse Pte. 30
Leader, Luther R.....801 S. Adams, Birmingham
Leaver, L. Ross.....757 Lakewood Ave., Detroit 15
Lebamoff, Alexander T.....7940 Allen Rd., Allen Park
Lechner, Monroe S.....22770 Kelly Rd., East Detroit
Lecklider, A. F. (R)....848 Berkshire Rd., Grosse Pte. 30
Lee, Edith J.....2424 Puritan, Detroit 21
Lee, Frank.....501 Meadowlane Dr., Dearborn
Lee, Harry E. (L).....13616 Gratiot Ave., Detroit 5
Lee, Pyong Tai.....26559 Grand River, Detroit
Lehmann, Robert N.....26029 W. 5 Mile Rd., Detroit 39
Leipsitz, Louis S.....3566 Cass Ave., Detroit 1
Leiter, Forrest C.....2355 Monroe, Dearborn
Leithauser, Danl. J. (L).....18412 Mack, Detroit 36
Leland, Solomon.....6563 Grand River, Detroit 8
Lemley, Clark F.....3011 W. Grand Blvd., Detroit 2
Lemmer, John A.....6609 Van Dyke, Detroit 13
Lemmon, Chas. E. (L).....1337 David Whitney Bldg., Detroit 26
Lemon, Bruce K.....1202 Maccabees Bldg., Detroit 2
Lentine, James J.....15831 Mack Ave., Detroit 24
Lenz, Willard R.....418 Moran Rd., Detroit 36
Lenzo, Joseph E.....951 E. Lafayette, Detroit 7
Lepard, Cecil W.....1553 Woodward Ave., Detroit 26
Lepley, Fred O. (L).....19799 Mack Ave., Grosse Pte. Woods
Lepley, Frederick J.....19803 Mack, Grosse Pte. 36
Lerman, Saml. I.....18330 Parkside, Detroit 21
Lerner, Leonard H.....7310 W. 7 Mile Rd., Detroit 21
Lesesne, John M.....17700 Mack Ave., Grosse Pte. 24
Leslie, C. G.....8401 Woodward, Detroit 2
L'Esperance, Simon P. (R).....Route 3, Woodslee, Ont., Canada
Lessem, David.....12759 Vernon, Huntington Woods
Leszynski, Jos. S. (L).....10 Peterboro St., Detroit 1
Leucutia, Traian (L).....10 Peterboro, Detroit 1
Levagood, Floyd B.....14056 Artesian, Detroit 23
Levant, Arthur B.....15715 E. Warren, Detroit 24
Levenson, Malcolm L.....24500 Custis, Southfield
Leventer, Ira.....20211 Ann Arbor Trail, Dearborn
Levin, David M. (A).....2100 N. Sahnara, Tucson, Ariz.
Levin, Herbert G.....17300 Schaefer, Detroit 35
Levin, M. Mitchel.....5057 Woodward Ave., Detroit 2
Levin, Saml. J.....3011 W. Grand Blvd., Detroit 2
Levine, Edward E...12891 Sherwood, Huntington Woods
Levine, Leonard.....15357 Farmington, Livonia
Levine, Sydney S.....8233 W. Chicago Blvd., Detroit 4
Levitt, Irving.....24535 N. Carolina, Southfield
Levitt, Nathan.....607 Kales Bldg., Detroit 26
Levy, David B.....29586 Fenkell, Livonia
Levy, Marvin B.....23200 Woodward Ave., Ferndale
Levy, Stanley H.....10601 7 Mile Rd., Detroit 21
Lewin, Harry (L).....10 Peterboro, Detroit 1
Lewis, Benjamin M.....1401 Rivard, Detroit 7
Lewis, Chas. T. (L).....5050 Joy Rd., Detroit 4
Lewis, Harvey Y.....14434 W. McNichols Rd., Detroit 35
Lewis, J. Hugh.....1543 Ford Ave., Wyandotte
Lewis, Lee A.....2730 E. Jefferson Ave., Detroit 7
Lewis, Robt. H.....14807 W. McNichols, Detroit 35
Lewis, Wilfrid J.....10 Peterboro St., Detroit 1
Libbrecht, Robt. V.....6540 Park Ave., Allen Park
Lichter, Max L.....2900 Oakwood Blvd., Melvindale
Lichty, Dorman E.....7701 Wyoming, Detroit
Liddicoat, Arthur G.....20125 Fenkell, Detroit 23
Lieberman, Barnard L...19212 Woodward Ave., Detroit 3
Lightbody, James J.....1553 Woodward Ave., Detroit 26
Lignell, John H. Route # 3 Division St. Charlevoix
Lignell, Rudolph W.....14200 Puritan, Detroit 27
Lilly, Robert P.....29594 W. 5 Mile Rd., Livonia
Lindner, David W...801 David Whitney Bldg., Detroit 26
Linkner, Leonard S.....12944 LaSalle Lane, Huntington Woods
Lipinski, Stanley L.....7540 Michigan Ave., Detroit 10
Lipkin, Ezra.....5715 Michigan Ave., Detroit 10
Lipnik, Carl E.....31610 Plymouth Rd., Livonia
Lipnik, Morris J.....15101 W. 7 Mile Rd., Detroit 35
Lipschutz, Louis S.....19750 Chesterfield Rd., Detroit 21
Lipson, Channing T.....16815 James Couzens, Detroit 35
Lipson, Madeleine L.....1800 Tuxedo, Detroit 6
Lipton, Raymond F.....10 Peterboro St., Detroit 1
Litsky, Abraham D.....1183 E. Grand Blvd., Detroit 11
Little, James W.....3637 Franklin Rd., Bloomfield Hills
Litwin, Jack A.....15121 W. McNichols Rd., Detroit 35
Litzenberger, D. J.....1386 E. Grand Blvd., Detroit 11
Livingood, Clarence S.....345 University, Grosse Pte. 30
Lloyd, James R.....1515 David Whitney Bldg., Detroit 26
Lo, Lien Fu.....1800 Tuxedo, Detroit 6
Lockhart, Edward C.....5005 Tireman, Detroit 4
Lockwood, Bruce C. (L).....19490 Parkside Ave., Detroit 21
Lofstrom, James E.....1420 St. Antoine St., Detroit 26
Logrippo, Annie B.....Henry Ford Hospital, Detroit 2
Lohmann, Carl W.....1229 David Whitney Bldg., Detroit 26
London, Berton L.....18510 Meyers, Detroit 35
Long, Earl C. (L).....19751 James Couzens Hwy., Detroit 35
Long, John J.....15901 Greenfield Ave., Detroit 27
Longo, Salvatore.....468 Cadieux, Detroit 30
Lookanoff, Victor A.....369 Glendale Ave., Highland Park 3
Lopatin, Reuben.....1800 Tuxedo, Detroit 6
Loranger, C. B. P.....20825 Mack, Detroit 36
Loranger, Guy L.....34 Moross Rd., Detroit 36
Lorber, Jos. H.....873 Lakewood Ave., Detroit 15
Lorentzen, Edwin H. (L).....11702 Grand River Ave., Detroit 4
Lovas, Wm. S.....6354 W. Fort St., Detroit 9
Love, Donald M.....703 Parker, Apt. 4, Detroit 14
Love, W. Thos.....231 E. Warren Ave., Detroit 1
Lowe, Adolf W.....3338 W. Davison Ave., Detroit 38
Lowe, Townsend G.....218 Kirby, Detroit 2
Lowinger, Paul L.....951 E. Lafayette, Detroit 7
Lowrie, Wm. L.....2799 W. Grand Blvd., Detroit 2
Luby, Elliot D.....19680 Roslyn Rd., Detroit 21
Lui, Alfred H. F.....Wayne Co. Gen. Hospital, Eloise
Lukas, John R.....18551 W. Warren, Detroit 28
Lumpkin, John G., Jr.....243 E. Warren Ave., Detroit 1
Lutz, Earl F.....3044 W. Grand Blvd., Detroit 2
Lutz, Sherwin J.....15121 W. McNichols, Detroit 35

Luz, Denis A.....Detroit Memorial Hosp., Detroit 26
Luzadre, John H.....18430 Mack Ave., Detroit 36
Lynn, David H.....Lynn Hospital, Lincoln Park
Lynn, Harvey D.....3815 Pelham Rd., Dearborn
Lytle, Robt. P.....10 Peterboro St., Detroit 1
Maben, Hayward C., Jr. (A).....9114 Dexter Blvd., Detroit 6
Mabley, John D...1037 David Whitney Bldg., Detroit 26
MacCraken, F. L. (A).....Dekoven Foundation, Racine, Wis.
MacDougall, Orrin P...13700 Woodward Ave., Detroit 3
MacFarlane, Howard W.....1553 Woodward Ave., Detroit 26
MacGregor, Wm. W. (L).....6320 W. Surrey St., Birmingham
Mack, Harold C.....3011 W. Grand Blvd., Detroit 2
Mack, Robert E.....Woman's Hospital, Detroit 1
MacKenzie, Frank M. (R).....205 Rivard Blvd., Grosse Pte. 30
MacKenzie, John W. (L).....289 Rivard Blvd., Grosse Pte. 30
Mackersie, Wm. G.....18205 Roselawn Ave., Detroit 21
Mackler, Harry S.....1800 Tuxedo, Detroit 6
MacLeod, Chas. W.....16345 W. McNichols, Detroit 35
Macmillan, Francis B...1553 Woodward Ave., Detroit 26
MacPherson, K. C.....8100 E. Jefferson, Detroit 14
MacQueen, Malcolm D. (L).....660 Woodward Ave., Detroit 26
Maczewski, John E.....24735 Van Dyke, Centerline
Mader, Ivan J.....26111 Woodward Ave., Huntington Woods
Magnell, Ralph C.....8825 Puritan Ave., Detroit 38
Maguire, Clarence E.....1553 Woodward Ave., Detroit 26
Mahanti, Biresh C.....2331 Van Alstyne, Wyandotte
Mahlin, Murray S.....16820 Greenfield Ave., Detroit 35
Mahoney, Hugh M.....1553 Woodward Ave., Detroit 26
Maibauer, Fredk. P.....2934 Biddle Ave., Wyandotte
Mainwaring, Rosser L.....1910 Russell, Dearborn
Mainzer, Jacob.....36475 5 Mile Rd., Livonia
Maire, Edward D.....15224 E. Jefferson, Detroit 30
Maitland, Ruth J.....Mich. Bell Telephone, Detroit 26
Majauskas, V. E.....23738 Joy Rd., Detroit 39
Majzoub, Ahmad J.....3334 Fort, Lincoln Park
Malina, Stephen.....1601 Kirkway Dr., Rt. 3, Bloomfield Hills
Malje, Frank J.....Garden City Clinic, Garden City
Malone, John M.....17300 Schaefer Rd., Detroit 35
Maloney, John A.....670 Maccabees Bldg., Detroit 2
Maloney, Philip J.....16401 Grand River, Detroit 27
Maltzer, Jos. H.....950 E. State Fair, Detroit 3
Mammel, Bernard T.....14447 W. 7 Mile Rd., Detroit 35
Mandel, Leslie.....14444 W. McNichols Rd., Detroit 35
Mandell, Gerald H.....Sinai Hospital, Detroit 35
Mandiberg, Jack N.....12700 W. 7 Mile Rd., Detroit 35
Mann, Andrew D.....20901 Moross, Detroit 36
Manning, Morey H.....950 E. State Fair Ave., Detroit 3
Manson, Gordon.....Henry Ford Hospital, Detroit 2
Mapletoft, Kenneth E.....420 Mohawk, Dearborn
Marcus, Edwin L.....15101 Southfield, Allen Park
Marecki, Vincent J.....10326 W. Warren, Dearborn
Margules, Saul Z.....11846 E. McNichols, Detroit 5
Marinus, Carleton J. (L).....1553 Woodward Ave., Detroit 26
Mark, Jerome.....513 David Whitney Bldg., Detroit 26
Markey, Alexander P.....14853 Michigan Ave., Dearborn
Markey, Frank R.....17174 Fairfield, Detroit 21
Marks, Ben.....232 W. Grand River Ave., Detroit 26
Marks, Bert W.....8250 Lincoln Dr., Huntington Woods
Marsh, Alton R.....15696 Woodland Dr., Dearborn
Marshall, James R.....14827 E. Jefferson Ave., Detroit 15
Marshall, J. R., Jr.....20160 Mack Ave., Detroit 36
Martin, J. B., Jr.....449 E. Elizabeth St., Detroit 1
Martin, Lyndle R.....2000 Second Blvd., Detroit 26
Martin, Peter A.....857 Fisher Bldg., Detroit 2
Martin, Walter.....17523 Dequinder, Detroit 12
Martin, Wilbur C.....2536 W. Grand Blvd., Detroit 6
Martineau, Perry C.....16709 Glastonbury, Detroit 19
Martinez, Pedro O.....1439 Bagley Ave., Detroit 16
Martmer, Edgar E.....693 Washington Rd., Grosse Pte. 30
Marwil, Thos. B.....17563 Greenfield Rd., Detroit 35
Mateer, John G. (L).....Henry Ford Hospital, Detroit 2
Matthews, Burton V.....13724 W. Fort St., Southgate
Mattman, Paul E.....1500 Seminole, Detroit 14
Mauch, Eugene W.....15101 Southfield, Allen Park
Mauthe, Harry G.....16859 Pollyana Dr., Livonia
Maynard, Fredk. M.....6828 Park Ave., Allen Park
McAlonan, William T. (L)....10 Peterboro St., Detroit 1
McAlpine, Gordon S. (L).....3011 W. Grand Blvd., Detroit 2
McBryan, Thos. J.....Grace Hospital, Detroit
McCadie, James H.....13700 Woodward Ave., Highland Park 3
McCandless, Virginia.....2355 Monroe, Dearborn
Mc Caughey, R. S.....Wayne St. University, Detroit 7
McClellan, Robt. J.....16345 W. McNichols, Detroit 35
McClelland, Rachel L.....33026 5 Mile Rd., Livonia
McClendon, James J.....8401 Woodward, Detroit 2
McClintock, John J. (L).....16151 Schoolcraft Ave., Detroit 27
McClure, Robt. W.....9111 E. Outer Dr., Detroit 13
McClure, Wm. R. (L).....Box 1498, Boynton Beach, Fla.
McCole, C. E.....Henry Ford Hospital, Detroit 2
McColl, Chas. W.....2025 Ford Ave., Wyandotte
McColl, Clarke M.....2799 W. Grand Blvd., Detroit 2
McCollum, E. Bert.....1553 Woodward Ave., Detroit 26
McCord, Carey P. (L)..Sch. of Public Health, Ann Arbor
McCormick, Colin C.....24352 Rockford Ave., Dearborn
McCue, Francis B.....6742 Park Ave., Allen Park
McCullough, L. E.....1711 David Whitney Bldg., Detroit 26
McDonald, Angus L. (L).....15125 Gratiot, Detroit 5
McDonald, John R.....Harper Hospital, Detroit 6
McDonald, Wm. G.....15600 Michigan Ave., Dearborn
McDowell, Douglas B.....Wayne Co. Gen. Hosp., Eloise
McEvitt, Wm. G.....1140 W. Boston Blvd., Detroit 2
McFadyen, Hugh A (L).....10 Peterboro St., Detroit 1
McGee, T. Manford.....2799 W. Grand Blvd., Detroit 2
McGillicuddy, W. E. (R).....7542 Pinehurst, Dearborn
McGinnis, Kenneth D.....Henry Ford Hospital, Detroit 2
McGlaughlin, N. D.....2312 Biddle Ave., Wyandotte
McGough, Jos. M.....18716 Grand River, Detroit 23
McGuire, John F.....10 Cherry Hill Ct., Dearborn 7
McHenry, John T.....1401 Rivard St., Detroit 7
McIntosh, Robt. D.....6307 W. Fort St., Detroit 9
McIntyre, Jack B.....2841 Monroe Blvd., Dearborn
McIntyre, Wm. B...1145 David Whitney Bldg., Detroit 26
McKean, G. Thos.....1553 Woodward Ave., Detroit 26
McKeever, Geo. E.....5237 Oakman Blvd., Dearborn
McKenna, Chas. J.....14618 E. 7 Mile, Detroit 5
McKnight, Robert E.....20905 Greenfield, Southfield
McLane, Harriet I. E. (L)..4350 Oregon Ave., Detroit 4
McLean, Brita R.....1365 Cass, Detroit 26
McLean, Don W.....1066 Fisher Bldg., Detroit 2
McLean, Donald C.....10 Peterboro, Detroit 1
McNamara, Joseph M.....9430 S. Main, Plymouth
McNeill, Roger F.....119 Kercheval, Grosse Pte.
McNichol, L. J.
McPhee, Roderick T.....21503 Harper, St. Clair Shores
McPherson, Robt. J. (L)....12626 Meyers Rd., Detroit 27
McQuiggan, Mark R.....700 Seward, Detroit 2
McQuiggan, Thelma H.....1250 Middlebelt Rd., Inkster
Meek, Stuart F.....13020 Kilbourne, Detroit 13
Melander, L. W., Jr.....1229 David Whitney Bldg., Detroit 26
Mellen, Hyman S.....16800 Greenfield, Detroit 35
Mellinger, Raymond C.....959 Pemberton, Grosse Pte.
Melnik, Maxim P.....3011 W. Grand Blvd., Detroit 2
Melnyczuk, Nestor.....7304 Michigan, Detroit 10
Menagh, Frank R. (L)....4010 Columbus Ave., Detroit 4
Mendelson, Charles G.....Henry Ford Hospital, Detroit 2
Mendelson, Herbert (A)..15200 Northfield, Oak Park 37
Mendelssohn, Reuben J.....14427 Mack Ave., Detroit 15
Mendians, Edgar V.....9486 Beaconsfield, Detroit 24
Mendoza, Saml.....6356 Michigan, Detroit
Menton, Norman J.....15300 W. McNichols, Detroit 35
Merkel, Chas. C.....85 Kercheval Ave., Grosse Pte. Farms

Merkle, Karl.....530 N. Telegraph, Dearborn
Merrill, C. R., Jr.....22883 Brookside Ct., Dearborn
Merritt, Earl G.....10 Peterboro St., Detroit 1
Mersky, Charlotte I. (A)..32215 Queensboro, Farmington
Metes, John S.....62 Webber Pl., Grosse Pte. Shores
Metzger, Harry C.....25504 Wareham, Huntington Woods
Meyer, Eugene (A).....17041 Pinecrest Dr., Allen Park
Meyer, John S.....Wayne State University, Detroit 7
Meyer, Kenneth R.....Oakwood Hospital, Dearborn
Meyers, Marjorie P.....5320 John R St., Detroit 2
Meyers, Maurice P.....18984 Livernois, Detroit 21
Meyers, Sidney S.....28477 Hoover, Warren
Meyers, Solomon G.....5057 Woodward Ave., Detroit 2
Michael, Michael J.....703 Mutual Bldg., Detroit 26
Mihay, Benjamin.....2021 Monroe, Dearborn
Mikesell, W. B., Jr.....23611 Goddard, Taylor
Mileris, Vytautas.....2730 E. Jefferson Ave., Detroit 7
Millard, Glenn E.....2900 W. Grand Blvd., Detroit 2
Miller, Danl. H.....23100 Cherry Hill, Dearborn
Miller, Elmer B.....20 Oxford Rd., Pleasant Ridge
Miller, Jacob J.....20131 James Couzens, Detroit 35
Miller, J. Martin.....2799 W. Grand Blvd., Detroit 2
Miller, Karl L.....1553 Woodward Ave., Detroit 26
Miller, Leroy A. (A).....Woman's Hospital, Detroit
Miller, Myron H...27330 Southfield Rd., Lathrup Village
Miller, Oscar W.....Fleetwood Plant, FBD, GMC, Detroit 9
Miller, Thos. H.....1305 David Whitney Bldg., Detroit 26
Miller, Wm. E. (L).....10 Peterboro, Detroit 1
Miller, William J.....5649 Inkster Rd., Garden City
Mills, Clinton C...16190 James Couzens Hwy., Detroit 21
Mills, Geo. R.....8209 Allen Rd., Allen Park
Milton, S. Byron.....26560 W. Outer Dr., Lincoln Park
Mines, Robert E., Jr.....8401 Woodward Ave., Detroit 2
Mintz, Edward I.....954 Fisher Bldg., Detroit 2
Mintz, Morris J.....16895 Livernois St., Detroit 21
Minui, Morteza.....1144 Carlson, Wayne
Miral, Solomon P.....4825 E. McNichols Rd., Detroit 12
Mishelevich, Sophie.....4651 E. 9 Mile Rd., Van Dyke
Miskinis, Martyna.....393 W. Grand Blvd., Detroit 16
Missavage, Edward, Jr...Wayne Co. General Hosp., Eloise
Mitchell, A. W.....12000 Visger, Detroit
Mitchell, C. Leslie.....Henry Ford Hospital, Detroit 2
Mitchell, Darnell P.....8401 Woodward, Detroit 2
Mitchell, Ralston S.....243 E. Warren, Detroit 1
Mitchell, Roy A.....Det. Memorial Hosp., Detroit 26
Moehlig, Robt. C. (L)....3001 W. Grand Blvd., Detroit 2
Moghissi, Kamran S.....763 David Whitney Bldg., Detroit 26
Mogill, Geo.....3150 Second Blvd., Detroit 1
Moisides, Vasil P. (L).....28 W. Adams Ave., Detroit 26
Moll, Clarence D.....10 Peterboro St., Detroit 1
Molnar, Stephen K.....4525 S. Telegraph Rd., Dearborn
Molner, Jos. G.....Wayne Co. Health Dept., Eloise
Momcilovich, Boxidar..2241 Huron River Dr., Rockwood
Mond, Edward.....10 Witherell St., Detroit 26
Monson, Robt. C.....17520 Chester, Detroit 24
Montante, Jos. R.....18715 Bretton Dr., Detroit 23
Montgomery, Wm. C.....25717 Coolidge, Oak Park 37
Monto, Raymond W.....Henry Ford Hospital, Detroit 2
Moore, John W., Jr.....8425 W. 8 Mile Rd., Detroit 21
Moore, Warren R.....608 Eastland Professional Bldg., 17800 E. 8 Mile Rd., Detroit 36
Mopper, Coleman.....14633 E. 7 Mile Rd., Detroit 5
Moran, Frank J.....27459 5 Mile Rd., Livonia
Morand, Louis J. (A).....18944 Fairfield, Detroit 21
Morgan, Donald N.....1553 Woodward Ave., Detroit 26
Moriarty, Geo. J.....3011 W. Grand Blvd., Detroit 2
Morita, Yoshikazu.....26111 Woodward Ave., Huntington Woods
Morley, Arthur R.....15753 Promenade, Allen Park
Morley, George M.....12922 W. Warren, Dearborn
Morley, Harold V.....970 Fisher Bldg., Detroit 2
Morley, James A. (L)....10514 Plymouth Ave., Detroit 4
Moroun, Sheffick J.....675 Parker, Detroit 14
Morris, Harold L. (L)....3001 W. Grand Blvd., Detroit 2
Morrison, George W.....2033 Park, Detroit 26
Morse, William H.....19203 Grand River, Detroit 23
Morton, David G.....19445 Plymouth, Detroit 28
Mosee, Wm. J.....9219 Dexter, Detroit 6
Moseley, Fredk. L.....2561 S. Schaefer, Detroit
Mosen, Max M.....8015 Harper Ave., Detroit 13
Moser, Peter F.....26151 Huron River Dr., Flat Rock
Moses, John W.....754 Fisher Bldg., Detroit 2
Moss, Nathan H.....2847 Trumbull, Detroit 16
Moss, Selma S.....18254 Livernois Ave., Detroit 21
Moszczynski, B. J.....1113 David Whitney Bldg., Detroit 26
Mott, Carlin P. (L).....2395 W. Grand Blvd., Detroit 8
Mott, Fredk. D.....6533 E. Jefferson, Detroit 7
Moynihan, John W.....2841 Monroe Blvd., Dearborn
Mozen, Herschel E.....12950 W. Chicago Ave., Detroit 28
Mucasey, John.....21415 W. 8 Mile Rd., Detroit 19
Muirhead, Ernest E.....432 E. Hancock, Detroit 1
Mullen, Jos. R.....19003 Ecorse Rd., Allen Park
Munson, Henry T.....18350 Mack, Grosse Pte. 36
Murphy, Donald J.....621 Professional Bldg., Detroit 1
Murphy, Scipio G.....603 E. Forest, Detroit 1
Murphy, Wm. M.....10500 E. Warren Ave., Detroit 14
Murray, Gordon M.....9901 Whittier, Detroit 24
Murray, Robt. J.....2299 West Rd., Trenton
Murray, Thomas H. (A).....25239 Southfield, Southfield
Muske, Paul H.....13244 W. Warren, Dearborn
Myers, Danl. W.....1150 Bedford Rd., Detroit 30
Nagle, John W. (L).....114 Maple St., Wyandotte
Nahigian, Russell.....17371 Annchester Ave., Detroit 19
Nahoum, Antoine.....1030 Kensington, Detroit 30
Nash, Edward B.....4075 Inkster Rd., Inkster
Naumoff, Normand....Detroit Memorial Hosp., Detroit 26
Navori, Cornelius A.....3516 Fort St., Lincoln Park
Naylor, Arthur H. (A).....10033 Tireman, Dearborn
Neeb, Walter G.....16840 E. Warren St., Detroit 24
Nehra, John M.....320 E. Center Prof. Bldg., Detroit 36
Neill, Edwin J.....8045 E. Jefferson St., Detroit 14
Nelson, Darwin M.....63 Ridge Rd., Detroit 36
Nelson, Harry M.....3001 W. Grand Blvd., Detroit 2
Nelson, Norman A.....Wayne Co. Gen. Hosp., Eloise
Nelson, Victor E.....3025 Crooks Rd., Royal Oak
Nesbit, Warren S.....474 Fisher Bldg., Detroit 2
Neufeld, Paul N.....19467 Livernois, Detroit 21
Newby, Burns G.....1104 Maccabees Bldg., Detroit 2
Newman, Ernest.....17371 Evergreen St., Detroit 19
Newman, Geo. F.....2021 Monroe Blvd., Dearborn
Newman, Max K.....16861 Wyoming Ave., Detroit 21
Newton, Kenneth.....11841 Susan Ave., Warren
Nichols, Wallace, Jr.....3631 S. Longmeadow, Trenton
Nickel, Warren O.....861 Monroe, Dearborn 8
Nickels, Albert W.....3011 W. Grand Blvd., Detroit 2
Nielsen, Aage E.....320 Professional Bldg., Detroit 1
Nielsen, Donald R.....26339 Woodward Ave., Huntington Woods
Nigro, Norman D.....7815 E. Jefferson, Detroit 14
Nill, John B.....15001 E. Warren, Detroit 24
Nill, Wm. F. (L).....15001 E. Warren, Detroit 24
Noble, Wm. C.....4045 W. Jefferson, Ecorse 29
Noe, Jo:. T., Jr.....Wyandotte Chem Corp., Wyandotte
Nolan, Bernard E.....5460 Schaefer Rd., Dearborn
Nolting, Wilfred S. H...15850 E. Warren Ave., Detroit 24
Northcross, David C.....2929 W. Boston Blvd., Detroit 6
Norton, Arthur B. (L)....5057 Woodward Ave., Detroit 2
Norton, Chas. S. (L).....11781 Eileen, Detroit 39
Noshay, Wm. C.....2799 W. Grand Blvd., Detroit 2
Novack, Richard L.....9924 Farmington Rd., Livonia
Novy, Robt. L. (L).....858 Fisher Bldg., Detroit 2
Nowosielski, P. F.....15256 Levan Rd., Livonia
Nunn, James W.....106 W. Davison, Detroit 3
Nyboer, Jan.....Harper Hospital, Detroit 1
O'Brien, Geo. M.....2501 W. Grand Blvd., Detroit 8
Obushkevich, Leon S. (A)..15720 W. Warren, Detroit 28
O'Connor, Katheryn L.....17711 Schoolcraft, Detroit 27
O'Donnell, Dayton H.....2501 W. Grand Blvd., Detroit 8
Oetting, Edward M.....2923 Iroquois Ave., Detroit 14
O'Gawa, Gilbert M.....Henry Ford Hospital., Detroit 2
Ohmart, Galen B.....8721 E. Jefferson Ave., Detroit 14
Ohrt, Harold F. (A).....285 E. Grand Blvd., Detroit 7
Okun, Milton H.....3261 Sherbourne Rd., Detroit 21
Olejniczak, Stanley.....Wayne County Gen. Hosp., Eloise

Olen, Alex.....13100 Harper Ave., Detroit 13
O'Linn, Francis P.....1055 Fisher Bldg., Detroit 2
Olmsted, Geo. S...27305 Southfield Rd., Lathrup Village
Olson, Avis M.....Mt. Carmel Mercy Hosp., Detroit 35
Olson, Donald T.....17701 W. McNichols Rd., Detroit 35
Olson, James A.....17000 West 8 Mile Rd., Southfield
Oppenheim, Jos. M.....24091 Dante, Oak Park 37
Organ, Fred W. (L).....1 Calvert, Detroit 2
Ormond, Robt. S.....1951 Monroe St., Dearborn
O'Rourke, Paul V.....2635 Woodstock, Detroit 3
O'Rourke, Randall M.....7384 12th St., Detroit 6
Osius, Eugene A.....1553 Woodward Ave., Detroit 26
Ostrowski, Arthur Z...949 Dav. Whitney Bldg., Detroit 26
Otlewski, Eugene A.....19647 Joy Rd., Detroit 28
Ottaway, John P.....18226 Mack Ave., Grosse Pte. Farms
Otto, Donald.....Det. Memorial Hospital, Detroit 26
Owen, Clarence I.....1544 Vinewood Ave., Detroit 16
Palmer, Alice E. (A).....U.S.O.M. Ph., A.P.O., 143, San Francisco
Palmer, Milton R.....8700 Dexter Blvd., Detroit 6
Palmisano, I. J.....25447 Plymouth Rd., Detroit 39
Pangburn, Leon E. (L).....12897 Woodward, Detroit 3
Panic, Stephen M.....1001 W. 7 Mile, Detroit 3
Parcells, Frank H.....1014 Buckingham, Grosse Pte. 30
Parfanowycz, S. N. (A).....3347 Grant St., Detroit 12
Parker, Albert R.....3720 Washington St., Wayne
Parker, Benj. R.....19149 W. 7 Mile Rd., Detroit 19
Parnell, John W.....21 Whitcomb Dr., Grosse Pte. Farms
Parr, Robt. W. (A)....1126 Audubon Rd., Grosse Pte. 30
Parrish, Rufus H. (A).....2610 Starlevant, Detroit
Pasternacki, N. T.....6203 Chene St., Detroit 11
Pastorius, Melvin K.....5947 Middlesex, Dearborn 1
Paul, Lloyd J.....25321 Fenkell, Detroit 39
Pawlowski, Jerome I.....2009 E. Grand Blvd., Detroit 11
Payne, Eugene H. (R).....General Delivery, Bonita Springs, Fla.
Payne, Walter A., Jr.....357 Hillcrest, Grosse Pte. 36
Paysner, Harry A.....13700 Woodward Ave., Highland Pk. 3
Peabody, Chas. W. (R).....25 Riverside Dr., Barrington, R. I.
Pearce, Arthur J.....15317 Piedmont St., Detroit 23
Pearlman, Jack.....25860 Concord, Huntington Woods
Pearse, Harry A.....17000 W. 8 Mile Rd., Southfield
Peat, Alexander C.....1350 Devonshire Rd., Grosse Pte. Park
Pedersen, Herbert E.....3815 Pelham Rd., Dearborn
Peggs, Geo. F.....5419 Livernois Ave., Detroit 10
Pendy, Geo. V.....1001 Dav. Whitney Bldg., Detroit 26
Pendy, John M.....1001 Dav. Whitney Bldg., Detroit 26
Pensler, Leslie.....10151 Michigan, Dearborn
Pensler, Meyer.....10149 Michigan Ave., Dearborn 2
Percy, Donald F.....15901 Greenfield Ave., Detroit 27
Perdue, Grace M.....3011 W. Grand Blvd., Detroit 2
Perez-Borja, C. M. (A).....Receiving Hospital, Detroit
Perkin, Frank S.....3011 W. Grand Blvd., Detroit 2
Perlis, Hyman L. (L).....10 Peterboro, Detroit 1
Perlis, Marvin S.....1030 Fisher Bldg., Detroit 2
Perry, Joseph H.....259 Lewiston Rd., Grosse Pte. 36
Peterman, Earl A.....13700 Woodward, Highland Park 3
Peters, Wm. R.....12400 E. 7 Mile Rd., Detroit 5
Peterson, Gustav.....Fisher Body, Willow Run, Ypsilanti
Peterson, Robert A.....17581 Prest, Detroit 35
Petix, Saml. C.....19207 Schaefer, Detroit 35
Petoskey, Edward A.....5656 W. Fort, Detroit 9
Petrick, Thos. J.....15101 Southfield, Allen Park
Petrini, Mario A.....1080 Fisher Bldg., Detroit 2
Petty, Thos. A.....1204 Yorkshire Rd., Detroit 30
Petz, Arthur John.....15420 Farmington, Livonia
Petz, Thomas J.....1139 Dav. Whitney Bldg., Detroit 26
Peven, Pauline.....18709 Myers Road, Detroit 35
Peven, Philip S.....18709 Meyers Rd., Detroit 35
Picard, Jos. D.....5237 Oakman Blvd., Dearborn
Piccone, Louisa I.....17700 W. Warren, Detroit 28
Pichette, J. Walton.....6650 Greenfield Rd., Dearborn
Pickard, Orlando W. (L).....14300 W. McNichols, Detroit 35
Pierce, James M., Jr.....Wayne St. University, Detroit 7
Pietra, A. W.....10338 Joseph Campau, Detroit 12
Pinckard, Karl G. (L).....5805 Evergreen, Dearborn 6
Pingel, James F.....998 Norfolk, Birmingham
Pink, Rose M.....11413 Joseph Campau, Detroit 12
Pinney, Lyman J. (L).....28 W. Adams, Detroit 26
Pino, Ralph H. (L)..48151 W. Ann Arbor Rd., Plymouth
Piper, Ralph R.....1495 McKinstry, Detroit 9
Pittman, John E. (L)....1553 Woodward Ave., Detroit 26
Pitts, Kenneth E.....17850 Maumee, Grosse Pointe
Platz, Carol K.....612 Est. Cen. Prof. Bldg., Detroit 36
Plavnick, Herman M.....13300 Fenkell, Detroit 27
Pliskow, Harold.....10730 W. 7 Mile Rd., Detroit 21
Plotnick, Harold.....18654 Muirland, Detroit 21
Plous, Eugene I.....569 Fisher Bldg., Detroit 2
Podolsky, Harold M.....3755 Fort, Lincoln Park
Poim, Senta V.....10 Peterboro, Detroit 1
Polentz, Chas. P.....Medical Concourse Northland Center, Southfield
Pollack, Jerome L.....14551 Southfield, Allen Park
Pollack, John J.....18200 Wyoming, Detroit 21
Pollard, R. J.....Grace Hosp., Detroit 1
Pollens, Louis S.....12730 W. McNichols Rd., Detroit 35
Pollina, Clement J.....21503 Harper, St. Clair Shores
Ponka, Jos. L.....2799 W. Grand Blvd., Detroit 2
Pool, Walter D.....20901 Moross Rd., Detroit 36
Poos, Edgar E.....3001 W. Grand Blvd., Detroit 2
Pope, Gerald.....Henry Ford Hospital, Detroit 2
Porretta, Chas. A.....622 Maccabees Bldg., Detroit 2
Porretta, Francis S.....8156 Normile Ave., Detroit 4
Porretta, George F.....1076 Maccabees Bldg., Detroit 2
Porter, Dwight H., Jr.....3919 John R St., Detroit 1
Porter, Fredk. G.....29590 5 Mile Rd., Livonia
Porter, Howard J. (A)....36911 Goddard Road, Romulus
Posch, Jos. L.....1410 Kales Bldg., Detroit 26
Posner, Irving.....18111 Muirland Ave., Detroit 21
Potts, Elihue B.....8943 Twelfth St., Detroit 6
Poznanski, Andrew K.....Henry Ford Hospital, Detroit 2
Pratt, Jean P. (L).....18910 Fairway Dr., Detroit 21
Pratt, Lawrence A. (A).....U.S.O.M., A.P.O. 143, San Francisco, Calif.
Preston, C. W.....4602 Brush St., Detroit 1
Preston, Ruth E.....3011 W. Grand Blvd., Detroit 2
Pribor, Hugo C.....3005 Iroquois, Detroit
Price, A. Hazen.....408 Dav. Whitney Bldg., Detroit 26
Price, Alvin E.....1553 Woodward Ave., Detroit 26
Priest, Robt. J.....Henry Ford Hospital, Detroit 2
Primack, Marvin H.....7430 Second, Detroit 2
Prince, Addison E.....8942 Dexter, Detroit 6
Prisbe, Edward J.....16603 Plymouth Rd., Detroit 27
Priver, Julien.....6741 W. Outer Dr., Detroit 35
Procailo, Alexander B.....29901 Ford Rd., Garden City
Proctor, Lorne D.....Henry Ford Hospital, Detroit 2
Prokop, Frank P.....7517 Appoline, Dearborn
Prokopovich, V.....19666 Conant, Detroit 34
Proskey, Aloysius J. (A)....16167 Glastonbury, Detroit 19
Proud, Robert H.....26151 Huron River Dr., Flat Rock
Proud, Russel F.....26151 Huron River Dr., Flat Rock
Prus, A. Michael.....4160 John R Street, Detroit
Prust, Frank W.....1536 Dav. Whitney Blvd., Detroit 26
Prystowsky, S.....1800 Tuxedo, Detroit 6
Pugh, Howard C.....1553 Woodward Ave., Detroit 26
Pugliesi, Angelo.....9489 E. Outer Dr., Detroit 13
Pugliesi, Benedetto.....9489 E. Outer Dr., Detroit 13
Purcell, Frank H. (L).....10 Witherell St., Detroit 26
Puro, Henry E.....1733 Trenton Dr., Trenton
Purves, W. L.....17595 Parkside, Detroit 21
Quigley, Eugene H.....111 Brentwood, Dearborn
Quigley, Wm. G.....1075 Fisher Bldg., Detroit 2
Quinn, Edward L.....1141 Golfview, Birmingham
Quinones, Rafael E.....17200 E. Warren, Detroit 24
Rabinovitch, Bella M.....20133 Marlowe, Detroit 35
Raby, Naim M.....15830 Fort, Southgate
Rachmaninoff, N.....Harper Hospital, Detroit 1
Radgens, Paul D.....Ford Motor Co., Highland Park
Rahm, Lambert P.....14411 E. Jefferson Ave., Detroit 15
Raiford, Frank P. (L)....1852 W. Grand Blvd., Detroit 8
Ralyea, Imbi.....16645 Freeland, Detroit 35
Ramos, Antonio E.....1800 Tuxedo, Detroit 6

Ramsey, Robt. H.....3815 Pelham Rd., Dearborn
Randall, David S.....3955 Fort St., Lincoln Park
Rapp, Seymour L.....5055 W. Outer Dr., Detroit 35
Raskin, Herbert A.....18510 Meyers Road, Detroit 35
Raskin, Morris.....15361 Plymouth Rd., Detroit 27
Rastello, Peter B. (R).....3295 West Shore Dr., Orchard Lake
Rattner, Wm. H.....1355 Dav. Whitney Bldg., Detroit
Rau, Fredk. W.....215 Professional Bldg., Detroit 1
Rausch, Nancy H.....11639 Turner, Detroit 4
Raven, Clara.....400 E. Lafayette, Detroit 26
Ravitz, Louis A.....12831 Burton Ave., Oak Park 37
Ray, Kenneth J.....28059 Elba Dr., Grosse Isle
Raynor, Harold F. (L).....49 Virginia Pk., Detroit 2
Razi, Massoud.....1214 S. Wayne, Wayne
Read, Raymond.....Wayne State Univ., Detroit 7
Rebandt, Raymond W.....2615 W. Jefferson, Trenton
Rebuck, John W.....2799 W. Grand Blvd., Detroit 2
Redding, Lowell G.....1336 Southfield Rd., Lincoln Park
Reder, Benjamin.....17301 W. 8 Mile Rd., Detroit 35
Redfern, W. Earl.....17392 Kirkshire St., Birmingham
Reed, H. Walter (L).....14447 W. 7 Mile Rd., Detroit 35
Reed, Ivor E.....1553 Woodward Ave., Detroit 26
Reed, Joseph O., Jr.....448 Lincoln, Detroit 30
Reed, Melvin L.....4160 John R. St., Detroit 1
Rees, Howard C.....15700 Mack Ave., Detroit 24
Reid, John G.....1553 Woodward Ave., Detroit 26
Reid, Wesley G.....3001 W. Grand Blvd., Detroit 2
Reidt, William U.....1800 Tuxedo, Detroit 6
Reiff, Morris V.....10241 Joy Rd., Detroit 4
Reinsh, Ernest R.....18674 Muirland Ave., Detroit 21
Reisig, Robert O.....20867 Mack, Detroit 36
Reisman, Nathan J.....15344 W. McNichols Rd., Detroit 35
Reisman, Saml. G.....1553 Woodward Ave., Detroit 26
Reive, David L. E.....25447 Plymouth, Detroit 39
Remski, James E.....29447 Ravine Dr., Livonia
Reno, George L.....970 Fisher Bldg., Detroit 2
Rentenbach, Robt. F.....314 Dav. Whitney Bldg., Detroit
Resto Soto, A. D.....17644 W. Warren, Detroit 28
Reutter, Carolyn.....22431 Trojan, Detroit
Reveno, Wm. S.....3001 W. Grand Blvd., Detroit 2
Reyner, Clarence E. (L).....10 Peterboro St., Detroit 1
Reynolds, Robt. M.....856 Fisher Bldg., Detroit 2
Rezanka, Harold J.....1553 Woodward Ave., Detroit 26
Rhoades, Francis P.....2414-16 Broderick Twr., Detroit 26
Rice, Harold B.....10 Peterboro St., Detroit 1
Rice, Meshel.....533 Coats Rd., Oxford
Richardson, Allan L. (R).....Naubinway
Rick, Paul J.....12673 Joan, Detroit 5
Riddell, Wilfred A.....15420 Farmington Rd., Livonia
Ridge, Ralph W. (L).....100 Oak St., Wyandotte
Rieckhoff, Geo. G. (L).....14905 E. Jefferson Ave., Detroit 15
Rieden, James A.....18053 Muirland, Detroit 21
Rieger, John B. (L).....746 Pallister, Detroit 2
Rieger, Mary H. (L)..19285 Lucerne Dr., Highland Park
Riethmiller, Robt. F.....12444 E. 7 Mile Rd., Detroit
Rinaldo, Joseph, Jr.....Henry Ford Hosp., Detroit 2
Rinkel, Robert W.....7319 Park Ave., Allen Park
Ritter, George.....28420 Sunset Blvd., Lathrup Village
Rivera, Emiliano, Jr.....1800 Tuxedo, Detroit 6
Rizzo, Paul.....16829 Harper, Detroit 24
Robb, Edward L.....17380 Livernois Ave., Detroit 21
Robb, Herbert F. (L).....381 Main St., Belleville
Robb, Herbert J.....2706 Comfort, Birmingham
Robb, J. Milton (L).....633 Dav. Whitney Bldg., Detroit 26
Roberts, Arthur J.....1310 Warwick Road, Lincoln Park
Roberts, George A.....7220 Gratiot Ave., Detroit 13
Robertson, Fredk. E 17000 W. 8 Mile Rd., Southfield
Robins, Samuel C.....24241 Seneca, Detroit 37
Robinson, Harold A.....10040 Yellowstone, Detroit 4
Robinson, Howard.....953 Fisher Bldg., Detroit 2
Robinson, James H., Jr...1553 W. Grand Blvd., Detroit 8
Robinson, Remus G.....3751 31st St., Detroit 10
Rodin, Ernst A.....951 E. Lafayette, Detroit 7
Roeglin, Orville F. F.....16800 E. Warren, Detroit 24
Roehl, Karl H.....1800 Grindley Park, Dearborn
Rogers, Aaron Z.....20451 Mack Ave., Detroit 36
Rogers, Geo. E. B.....2108 Dav. Broderick Twr., Detroit 26
Rogers, John T.....29586 5 Mile Rd., Livonia
Rogers, Robert P.....18980 Wyoming, Detroit 21
Rogin, James R.....19481 Livernois, Detroit 21
Rogoff, Abraham S.....17000 W. 8 Mile Rd., Southfield
Rohde, Paul C. (L).....12282 E. Outer Dr., Detroit 24
Rom, Jack.....8600 W. McNichols Rd., Detroit 21
Roman, Stanley J.....15020 Michigan Ave., Dearborn
Romanski, Raymond.....2500 W. Grand Blvd., Detroit 8
Ronayne, John J., Jr.....16345 W. McNichols Rd., Detroit 35
Rosbolt, O. Paul, Jr.....8505 Plymouth Rd., Detroit 4
Rosefield, John L.....65 W. Hancock, Detroit 1
Rosen, Theodore S.....19340 Monte Vista, Detroit 21
Rosenbaum, Herbert.....18110 Muirland, Detroit 21
Rosenbaum, Jean B.....19200 Canterbury, Detroit 21
Rosenbloom, Alvin B.....17555 Parkside, Detroit 21
Rosenfeld, L. S.....1800 Tuxedo, Detroit 6
Rosenthal, Albert.....27855 Plymouth Rd., Livonia
Rosenthal, Louis H.....15401 W. McNichols, Detroit 35
Rosenthal, Saml.....8844 Joy Rd., Detroit
Rosenwach, Felix F.....19149 W. 7 Mile Rd., Detroit 19
Rosenzweig, Norman.....6767 W. Outer Dr., Detroit 35
Rosenzweig, Saul.....2542 W. Boston, Detroit 6
Ross, Charles V.....7740 Da Costa, Detroit 39
Ross, Hyman.....17301 W. 8 Mile Rd., Detroit 35
Ross, Mervyn B.....9559 Greenfield, Detroit 27
Ross, Oscar A.....1800 Tuxedo, Detroit 6
Rotarius, Edward M.....Parke Davis Co., Detroit 32
Roth, Edward T. (L).....640 E. Grand Blvd., Detroit 7
Rothbart, Harold B.....25717 Coolidge, Oak Park
Rother, Ina A. C.....101 Chicago Blvd., Detroit 2
Rothwell, Walter S.....2730 Chelsea, Trenton
Rottenberg, Coleman M. J.....13419 Fenkell, Detroit 27
Rottenberg, E. N.....20725 W. 7 Mile Rd., Detroit 19
Rottenberg, Leon.....13419 Fenkell Ave., Detroit 27
Roubeck, William.....17000 W. 8 Mile Rd., Southfield
Rowda, Michael S.....7 Cambridge, Pleasant Ridge
Rowe, Jos. J., Jr.....401 N. Brady, Dearborn
Royer, Richard R.....18101 E. Warren Ave., Detroit 24
Rubinoff, William.....21415 W. 8 Mile Rd., Detroit 19
Ruble, Paul E.....1139 Dav. Whitney Bldg., Detroit 26
Rucker, Julian J.....668 Farnsworth Ave., Detroit 2
Ruedemann, Albert D...1553 Woodward Ave., Detroit 26
Ruedemann, Albert D., Jr.....1553 Woodward Ave., Detroit 26
Rueger, Milton J.....86 Hall Pl., Detroit 36
Rueger, Ralph C.....9149 E. Jefferson Ave., Detroit 14
Ruel, Richard E.....1515 Dav. Whitney Bldg., Detroit 26
Ruiz, Luis C.....35084 Chestnut, Wayne
Runge, Edward F. (A).....8295 39th Ave. N., St. Petersburg, Fla.
Rupe, Clarence E.....2799 W. Grand Blvd., Detroit 2
Rupp, Jacob R. (L).....2510 17th Street, Detroit 16
Rupprecht, Emil F.....5525 W. Chicago Blvd., Detroit 4
Rush, Desmond K...1429 Dav. Whitney Bldg., Detroit 26
Ruskin, Robert L.....Sinai Hospital, Detroit 35
Ruskin, Saml. H.....1112 Kales Bldg., Detroit 26
Russanow, Geo.....400 E. Lafayette, Detroit 26
Russell, Henry N., Jr.....15101 Southfield, Allen Park
Rutzen, Arthur C.....20211 Greenfield Rd., Detroit 35
Ryan, James M.....16888 Greenfield, Detroit 35
Ryan, Thomas E.....719 New Center Bldg., Detroit 2
Ryan, William D. (R).....P.O. Box 4335 Porter Sta., Detroit 9
Rydzewski, Jos. B.....12170 Joseph Campau Ave., Detroit 12
Sabbagh, Enrique.....2605 W. Grand Blvd., Detroit 8
Sack, Anthony G.....18230 Grand River, Detroit 23
Sadler, Henry H., Jr.....605 Lakeland, Grosse Pte. 30
Sadzikowski, Jos. T.....1730 Hawthorne, Dearborn
Sage, Bernard A.....1013 Haigh St., Dearborn
Sage, Edward O. (L).....415 Burns Dr., Detroit 14
Sager, Edward L.....13902 Gratiot Ave., Detroit 5

St. Louis, Rene J. (L).....10909 W. Jefferson Ave., River Rouge 18
Sakorraphos, S. N. (L).....1346 Broadway, Detroit 26
Sakwa, Saul.....19467 Livernois, Detroit 21
Salan, Lacy J.....995 S. Main St., Plymouth
Salchow, Paul T.....Herman Kiefer Hosp., Detroit 2
Salem, Edward S.....14520 Sherwood, Oak Park
Salhaney, Mitchell.....15252 Levan Rd., Livonia
Sall, Caroline D.....6246 Chase, Dearborn
Sallee, William T.....17000 W. 8 Mile Rd., Southfield
Saltzstein, Harry C. (L)....850 Whitmore Rd., Detroit 3
Salvaggio, A. T.....1807 Dav. Whitney Bldg., Detroit 26
Sand, Harry H.....24110 Oxford, Dearborn
Sandberg, Hershel.....19207 Schaefer, Detroit 35
Sanders, Alexander W.....16350 Hamilton, Detroit 3
Sanderson, Alvord R. (L).....978 Pemberton Rd., Grosse Pte. 30
Sanderson, Susanne M. (L).....18520 W. 7 Mile Rd., Detroit 19
Sandler, Nathaniel.....76 W. Adams Ave., Detroit 26
Santen, Wm. L.....755 W. Michigan, Jackson
Sapala, M. Andrew.....13021 Mackenzie Ave., Detroit 28
Saraf, Leo B.....14540 E. Warren, Detroit 15
Sargent, Douglas A.....816 Grand Marais, Grosse Pte. Pk.
Sargent, Richard C.....17357 Fenkell St., Detroit 27
Sargent, William R.....17357 Fenkell St., Detroit 27
Sarnacki, Carl J.....952 Fisher Bldg., Detroit 2
Sarracino, John B. (A).....U.S. Army Hospital, Ft. Ord, Calif.
Sauk, John J.....302 W. McNichols Rd., Detroit 3
Saulsberry, Guy O.....301 E. Kirby, Detroit 2
Sauter, Simon H. (L).....1082 E. Grand Blvd., Detroit 7
Savignac, Eugene M.....Holy Cross Hosp., Detroit 31
Sawdyk, Daria H.....7012 Mich. Ave., Detroit 10
Scarney, Herman D.....3011 W. Grand Blvd., Detroit 2
Schaefer, H. C.....7815 E. Jefferson, Detroit 14
Schaefer, Robert. L. (A)..76 W. Adams Ave., Detroit 26
Schaefer, Robt. L., Jr.....74 W. Adams Ave., Detroit 26
Schaeffer, J. N.....261 Brady, Detroit 1
Schaeffer, Martin.....18275 Warrington Dr., Detroit 21
Schakne, Norman.....669 Fisher Bldg., Detroit 2
Schane, David A.....17157 Mendota, Detroit 21
Schatten, Ivan C.....2201 E. Jefferson Ave., Detroit 7
Scheinberg, S. R.....2240 W. Grand Blvd., Detroit 8
Schembeck, Isaac S. (L).....1553 Woodward Ave., Detroit 26
Schidlowsky, Oleg P.....36200 Plymouth Rd., Livonia
Schiller, Arthur E. (L).....1553 Woodward Ave., Detroit 26
Schillinger, H. K.....300 Berkley, Dearborn
Schirack, Raymond D. (R).....Luzerne
Schkloven, Norman.....20051 Warrington, Detroit 21
Schlafer, Nathan H.....10 Witherell St., Detroit 26
Schlesinger, Henry.. 13534 Woodward Ave., Detroit 3
Schmaltz, John D...1701 Dav. Whitney Bldg., Detroit 26
Schmidt, Generva F 1074 Vernier Rd., Detroit 36
Schmidt, George J.....7106 Park Ave., Allen Park
Schmidt, Harry E.....24625 Fairmount Rd., Dearborn
Schmidt, Johann.....7815 E. Jefferson, Detroit 14
Schmidt, Klaus P.....871 Fisher Building, Detroit 2
Schmidt, Werner F.....1807 Stroh Bldg., Detroit 26
Schmier, Burton L. (A).....20051 Litchfield, Detroit 21
Schmitt, Norman L.....10127 W. McNichols Rd., Detroit 21
Schneck, Robt. J.....1553 Woodward Ave., Detroit 26
Schneider, Chas. L.....22148 Michigan Ave., Dearborn
Schneider, Curt P.....655 Fisher Bldg., Detroit 2
Schoenfield, Gilbert D.....8830 W. McNichols Rd., Detroit 21
Scholdager, Rolf H.....1800 Tuxedo, Detroit 6
Schooten, Sarah S.....13700 Woodward Ave., Highland Park 3
Schorer, Calvin E.....951 E. Lafayette, Detroit 7
Schroeder, Carlisle F.....26505 E. River Rd., Grosse Ile
Schroeder, Gisela (A).....10641 Meuse, Detroit 24
Schroeder, Heinz R.....Wayne Co. Gen. Hospital, Eloise
Schuchter, S. L.....1800 Tuxedo, Detroit 6
Schulte, Carl H.....28 W. Adams Ave., Detroit 26
Schultz, Clarence H.....23100 Cherry Hill, Dearborn
Schultz, Ernest C. (L)..1553 Woodward Ave., Detroit 26
Schuman, Bernard M.....Henry Ford Hospital, Detroit 2
Schwartz, Benj.....275 W. Grand Blvd., Detroit 16
Schwartz, Harold A.....7605 Puritan Ave., Detroit 38
Schwartz, Louis A.....P.O. Box 315, Rockport, Mass.
Schwartz, Oscar D.....7421 W. 7 Mile Rd., Detroit 21
Schwartzberg, J. A.....19445 Plymouth, Detroit 28
Schwarz, Frank W.....23100 Cherryhill, Dearborn
Schweigert, C. F.....10627 Cadieux Rd., Detroit 24
Schwimmer, Benjamin.....8811 John C. Lodge Bldg., Detroit 2
Schwocho, Niles H.....7106 Park Ave., Allen Park
Sciarrino, Stanley V.....15388 Livernois Ave., Detroit 38
Scott, Marrion U.....20170 Mack Ave., Detroit 36
Scott, Robert J.....7333 W. 7 Mile Rd., Detroit 21
Scott, Wm. J.....20170 Mack Ave., Grosse Pte. Woods
Screen, Raymond J.....18520 W. 7 Mile Rd., Detroit 19
Seabrooks, Benj. F., Jr.....9136 Oakland Ave., Detroit 11
Secord, Eugene W. (A)....660 Whitmore Rd., Detroit 21
Segal, Andrew E.....19481 Livernois Ave., Detroit 21
Segar, Laurence F.....10 Witherell St., Detroit 26
Segel, Nathan P.....19100 Manor, Detroit 21
Seibert, Alvin H. (L).....1180 Bedford Rd., Grosse Pte. Pk. 30
Seiferlein, A. L.....1553 Woodward Ave., Detroit 26
Seim, Elmer J.....Grace Hospital, Detroit 1
Seitam, Karl.....10149 Michigan Ave., Dearborn
Selbst, Ronald A.....1342 Maccabees Bldg., Detroit 2
Self, Wm. G.....20861 Mack Ave., Grosse Pte. 36
Sellers, Chas. W.....18545 Schoolcraft Ave., Detroit 23
Sellers, Graham A.....10535 W. 7 Mile Rd., Detroit 21
Seltzer, Joseph.....7441 W. 7 Mile Rd., Detroit 21
Selzer, Isidore.....4811 John R. St., Detroit 1
Senecoff, Stephen D.....16800 Greenfield, Detroit 35
Sepetys, Povilas.....25466 Clairview, Dearborn 6
Seski, Arthur G.....1069 Fisher Bldg., Detroit 2
Seto, Millard (A).....3218 Belle Court, Royal Oak
Severyn, Fred R.....22146 Ford Rd., Dearborn
Sewell, Geo. (L).....31801 Arlington Dr., Birmingham
Sewell, Guy W.....17751 East Warren Ave., Detroit 24
Seydel, H. Gunter.....847 Westchester, Grosse Pte. Pk.
Shada, John C.....770 Shoreham, Grosse Pte. 36
Shafarman, Eugene M.....5320 John R St., Detroit 2
Shaffer, Jos. H.....2401 Radnor Dr., Birmingham
Shaffer, Loren W. (R)..6040 Wildrose Lane, Port Huron
Shafter, Royce R.....1188 Puritan, Birmingham
Shams Avari, Parvis.....25210 Grand River, Detroit 40
Shanoski, Stanley J.....1910 Dav. Broderick Twr., Detroit 26
Shapiro, Jacob.....14634 E. 7 Mile Rd., Detroit 5
Shapiro, Reuben I.....910 Dav. Broderick Twr., Detroit
Shargel, Geo. M. J.....1800 Tuxedo, Detroit 6
Sharp, Elwood A. (A).....633 Neff Rd., Grosse Pte. 30
Sharpe, Wm. D.....24621 W. McNichols Rd., Detroit 19
Sharrer, Chas. H.....1133 Grayton, Detroit 30
Shatz, Irwin J.....2799 W. Grand Blvd., Detroit 2
Shaya, Ezra S.....25210 Grand River, Detroit 40
Sheehan, Irene C.....15520 Garfield, Allen Park
Sheehan, Shelia.....Det. Receiving Hosp., Detroit 26
Shekerjian, Armen....27640 Morningside, Lathrup Village
Sheldon, John A. (L).....1435 3 Mile Dr., Grosse Pte. Pk. 30
Shelton, Carl F.....952 Dav. Whitney Bldg., Detroit 26
Sheppard, Emma L. W. (R).....314 Main St., Fenton
Sherman, Marvin.....20101 James Couzens, Detroit 35
Sherman, W. LaRue (L).....10 Peterboro St., Detroit 2
Sherman, Wm. L., Jr. (A).....201 E. Kirby, Detroit 1
Sherrin, Edgar R.....19021 W. McNichols, Detroit 19
Shevin, Frederick F.....18450 Livernois, Detroit 21
Shewchuk, A. P.....7300 Allen Rd., Allen Park
Shields, Wm. L.....510 Hildale, Detroit 3
Shiffman, Milton M.....Mt. Sinai Hospital, Detroit 35
Shifrin, Peter G.....20211 Greenfield, Detroit 35
Shin, Eon.....1800 Tuxedo Ave., Detroit 6
Shiovitz, Louis.....5419 Michigan Ave., Detroit 10
Shipton, Waldo H. (A).....General Delivery, Naples, Fla.
Shlain, Benj.....10244 W. 7 Mile Rd., Detroit 21

Shors, Clayton M.....19635 Mack Ave., Detroit 35
Shortz, Gerald (A).....920 15th Place, Vero Beach, Fla.
Shreve, Alfred J.....4520 Firestone Ave., Dearborn
Shufro, Arthur S.....28585 Rivercrest Dr., Southfield
Shulak, Irving B.....10 Witherell St., Detroit 26
Shulman, Herschel A.....207 Northland Med. Bldg., Southfield
Shumaker, Edward J.....75 Lothrop, Detroit 36
Siddall, Roger S.....3011 W. Grand Blvd., Detroit 2
Sieber, Edward H.....6650 Greenfield Rd., Dearborn
Siebert, William E.....23023 Orchard Lake Rd., Farmington
Siefert, John L.....12720 E. Outer Dr., Detroit 24
Siefert, Wm. A.....17400 Grand River Ave., Detroit 27
Siegel, Henry.....19720 Chesterfield, Detroit 21
Siero, Jose M.....9105 Van Dyke, Detroit 13
Sievers, Lorraine A.....1457 Dav. Whitney Bldg., Detroit 26
Sigler, John W.....Henry Ford Hospital, Detroit
Sill, Jacob A.....19635 Mack Ave., Detroit 36
Siller, John J.....19244 Grand River, Detroit 23
Sillery, Robt. J.....857 Grosse Pte. Ct., Grosse Pte. 30
Sills, Richard D.....19321 Greenfield, Detroit 35
Silvarman, Israel Z.....9105 Van Dyke Ave., Detroit 13
Silver, Donald F.....467 Fisher Bldg., Detroit 2
Silver, Israel W.....20000 W. Chicago, Detroit 28
Silver, Robert R.....20188 Wakefield, Detroit
Silverman, Maurice M.....17301 W. 8 Mile Rd., Detroit 35
Silverman, Max (L).....2240 W. Grand Blvd., Detroit 8
Silverstone, I. A.....16448 Alpine, Livonia
Simmons, Donald R.....958 Fisher Bldg., Detroit 2
Simon, Heinz G.....12206 Morang, Detroit 24
Simpson, Gordon E.....18101 E. Warren Ave., Detroit 24
Simson, Clyde B.....951 E. Lafayette, Detroit
Singer, Floyd W.....13530 Michigan Ave., Dearborn
Sippola, Geo. W.....13603 LaSalle Blvd., Detroit 38
Sisson, John M.....15901 Greenfield Ave., Detroit 27
Sivak, B. J.....24604 Templar, Southfield
Sklar, Manuel.....18400 Schaefer Rd., Detroit
Skully, Edward J.....14000 Linnhurst, Detroit 5
Sladen, Frank J. (L).....Henry Ford Hospital, Detroit 2
Slahetka, Vincent E.....19334 Bretton Drive, Detroit 23
Slaugenhaupt, J. G. (L).....16887 Lawton, Detroit 21
Slaughter, Fred M. (L).....2562 Fery Park, Detroit 8
Slazinski, Leo W.....7618 Michigan Ave., Detroit 10
Slevin, John G.....10 Witherell St., Detroit 26
Sliwin, Edward P.....13244 W. Warren, Dearborn
Slusky, Jos.....854 Fisher Bldg., Detroit 2
Slutzky, Gilbert.....18614 Warrington, Detroit 21
Slutzky, Robert J.....12950 W. Chicago, Detroit 28
Sly, Robt. F.....2101 Monroe Blvd., Dearborn 8
Small, Henry.....11507 Hamilton Ave., Detroit 2
Smathers, Homer M.....14219 W. McNichols, Detroit 35
Smathers, Ward M.....14219 W. McNichols, Detroit 35
Smeck, Arthur R. (L).....1036 Waterman Ave., Detroit 9
Smiggen, James J.....19647 Joy Rd., Detroit 28
Smith, Andrew J.....2950 Puritan, Detroit 38
Smith, Claude A. (L).....7 Adams Lane, Dearborn
Smith, Douglas H.....10151 Michigan, Dearborn 2
Smith, F. Janney (L).....352 Moselle Pl., Grosse Pte. Farms
Smith, Henry L.....16401 Grand River Ave., Detroit 27
Smith, J. Allen.....14140 Puritan Ave., Detroit 27
Smith, Richmond W., Jr.....2799 W. Grand Blvd., Detroit 2
Smith, Roger F.....18755 Wilshire Ave., Lathrup Village
Smith, W. Pierce.....Henry Ford Hospital, Detroit 2
Smolenski, John J.....13815 Puritan Ave., Detroit 27
Smyka, Stanley M.....15731 Glenwood, Detroit 5
Snider, Thomas H.....V.A. Hospital, Dearborn
Snoke, Edwin C.....3418 Norwood, Trenton
Snow, Linwood W.....508 W. Main St., Northville
Snyder, Richard J.....32817 Barkley, Livonia
Soble, Allen R.....18241 Greenfield, Detroit 35
Sobel, Robt. A.....18980 Wyoming, Detroit 21
Soderberg, Ralph B.....7815 E. Jefferson Ave., Detroit 14
Soifer, Sidney.....Sinai Hospital, Detroit 35
Sokol, Wm. M.....15800 W. McNichols, Detroit 35
Sokolov, Raymond A.....3011 W. Grand Blvd., Detroit 2
Sokolowski, A. H.....5550 Mitchell Ave., Detroit 11
Solberg, Lincoln E.....2021 Monroe, Dearborn
Soller, Alex S.....19309 Greenfield, Detroit 35
Solomon, A. B.....9559 Greenfield, Detroit 27
Solomon, Robert J.....15101 Southfield, Allen Park
Somerville, Thos. H.....36475 5 Mile Rd., Livonia
Sonda, Lewis P.....1553 Woodward Ave., Detroit 26
Sonda, Lewis P., Jr.....5132 Allen Rd., Allen Park
Sorock, Milton L.....19467 Livernois, Detroit 21
Sosa, Carlos M. A...10824 Talbot St., Huntington Woods
Speck, Carlos C.....6742 Park Ave., Allen Park
Spector, Maurice J.....12938 E. Jefferson, Detroit 15
Sperry, Frederick L. (A)..490 Arlington, Berkeley, Calif.
Sphire, Raymond D.....4160 John R St., Detroit 1
Spiegelmann, H. L.....15361 Plymouth, Detroit 27
Spiro, Adolph S.....13240 Harper, Detroit 13
Springborn, Benj. R. (L).....15818 E. Warren Ave., Detroit 24
Sprunk, Carl J.....2900 Oakwood Blvd., Melvindale
Spurrier, Ethelbert.....1553 Woodward Ave., Detroit 26
Squires, Walter M. (R).....1616 S. 28 Ave., St. Petersburg, Fla.
Stalker, Hugh (R).....Cottage Hospital, Grosse Pte. Farms
Stamell, Benjamin B.....123 Cass, Mt. Clemens
Stamell, Meyer.....14634 Greenfield St., Detroit 27
Staniszewski, C.....8581 Pinehurst, Detroit 4
Stanton, James M.....1001 Mutual Bldg., Detroit 26
Stanton, Myron R.....3400 W. Warren, Detroit 8
Stapleton, Wm. J., Jr. (L)..201 E. Kirby Ave., Detroit 2
Staricco, Renato.....3725 Fort St., Lincoln Park
Starrs, Thos. C. (L).....1122 Kensington Rd., Detroit 30
Staryk, Steven E.....1010 N. Oxford Rd., Detroit 36
Statzer, Darrell E.....955 Fisher Bldg., Detroit 2
Staub, Howard P.....37625 Michigan Ave., Wayne
Staudt, Louis W.....1201 Pilgrim, Birmingham
Stearns, Alexander B.....7430 Second, Detroit 2
Stebbins, Chas. E.....664 Fisher Bldg., Detroit 2
Steepe, Chas. A. D.....20867 Mack, Grosse Pte. Woods
Stefani, Andrew E.....1701 N. Renaud, Detroit 36
Stefani, Ernest L.....18600 Birchcrest, Detroit 21
Stefani, Raymond T.....13526 Stoepel, Detroit 38
Stein, Albert H.....19334 San Juan Dr., Detroit 21
Stein, Emory.....13115 Woodward, Detroit 3
Stein, Harvey S.....19075 Middlebelt Rd., Livonia
Stein, Saul C.....23105 Van Dyke, Van Dyke
Steinbach, A. L.....320 Merriweather Rd., Grosse Pte. 36
Steinberger, E. J. (L).....6402 W. Fort, Detroit 9
Steiner, Fredk. B.....7675 Ridge Rd., Plymouth
Steiner, Gabriel (L).....10 Peterboro St., Detroit 1
Steiner, S. D.....3044 W. Grand Blvd., Detroit 2
Steinhardt, Milton J.....10720 W. 7 Mile Rd., Detroit 21
Stellhorn, Chester E.....12900 W. 7 Mile Rd., Detroit 35
Stellhorn, Mary C. (A).....16616 Mack Ave., Detroit 24
Stempel, Edward M.....18324 Fairfield Ave., Detroit 21
Sterba, Richard F.....1130 Parker Ave., Detroit 14
Stern, Edward A.....12710 Dexter Blvd., Detroit 38
Stern, Joseph W.....15101 W. Seven Mile, Detroit 35
Stern, Julian.....15121 W. McNichols Rd., Detroit 35
Stern, Leonard H.....19200 Aften Rd., Detroit 3
Stern, Louis D. (L).....1553 Woodward Ave., Detroit 26
Stern, Sheldon D.....802 Mutual Bldg., Detroit 26
Sternhill, Vernon.....1800 Tuxedo, Detroit 6
Stevens, Chas. H.....Med. Concourse Northland Center, Southfield
Stevenson, Chas. S.....19545 Park Lane, Grosse Ile
Stevenson, Lee B.....Henry Ford Hosp., Detroit 2
Stewart, Lula B.....8633 Dexter Blvd., Detroit 6
Stewart, Maitland N., Jr.....10 Peterboro St., Detroit 1
Stewart, Robert M.....15357 Farmington Rd., Livonia
Stewart, Marjorie (A).....581 Golfcrest, Dearborn
Stiefel, Danl. M.....1553 Woodward Ave., Detroit 26
Stillwater, Karl.....18221 Pennington, Detroit 21
Stith, Dwight E.....505 Owen St., Detroit 2
Stobbe, Godfrey D.....Grace Hospital, Detroit 1
Stock, Thomas B.....19610 Middlesex, Southfield

Stocker, Lawrence L.....7330 W. 7 Mile Rd., Detroit 21
Stocker, Marvin L.....16401 Grand River, Detroit
Stockwell, Benj. W.....3919 John R St., Detroit 1
Stokfisz, Thaddeus.....7012 Michigan, Detroit 10
Stoller, Raymond.....25210 Grand River Ave., Detroit 40
Stone, Sidney L.....14620 E. 7 Mile Rd., Detroit 5
Straith, Richard E.....2605 W. Grand Blvd., Detroit 8
Strand, Martin E.....22400 Cherry Hill, W. Dearborn
Strauss, Ernest G.....1326 St. Antoine, Detroit 26
Stricker, Henry D.....5624 W. Fort St., Detroit 9
Strickler, D. T., Jr.....22231 W. Outer Drive, Dearborn
Strickroot, Fred L.....3800 Bishop Rd., Detroit 24
Stronski, G. E.....9901 Whittier, Detroit 24
Stryker, Joan C.....21604 E. River Rd., Grosse Ile
Stryker, Walter A.....P.O. Box 31, Wyandotte
Stubbs, Clayton T. (R).....126 S. Gratiot, Mt. Clemens
Stubbs, Harold W. (L).....13930 Woodward Ave., Detroit 3
Subrin, Mayer.....18048 Woodingham, Detroit 21
Suen, Irene T. S.....3675 E. Outer Dr., Detroit 34
Sugar, David I.....18104 Oak Drive., Detroit 21
Sugar, H. Saul.....18140 San Juan Dr., Detroit 21
Sugarman, Marcus H.....15201 W. McNichols, Detroit 35
Sullivan, Hugh A. (L)..1553 Woodward Ave., Detroit 26
Sultzman, L. Carl.....55 Vendome, Grosse Pte. Farms 36
Summers, Wm. A.....1553 Woodward Ave., Detroit 26
Summers, Wm. S. (L).....402 N. Palmway, Lake Worth, Fla.
Sutherland, Jacob M. (L)....716 Pallister Ave., Detroit 2
Suwinski, Raymond H...9801 Conant St., Hamtramck 12
Swan, Donald C.....17000 W. 8 Mile Rd., Southfield
Swanson, Carl W.....936 Alter Rd., Detroit 15
Swanson, Raymond E. (A).....2753 Bailey, Dearborn
Swanson, Robt. G.....17800 E. 8 Mile Rd., Detroit 36
Swartz, Fred G., Jr.....1329 Dav. Whitney Bldg., Detroit 26
Sweeny, Donald N., Jr.....8445 E. Jefferson, Detroit 14
Switzer, Bertrand C. (R).....12246 Ilene, Detroit
Syphax, Charles S.....1819 E. Davison, Detroit 3
Szabunia, Sigmund C.....19600 Van Dyke, Detroit 34
Szappanyos, G. G.....Providence Hosp., Detroit 8
Szilagyi, D. Emerick.....Henry Ford Hospital, Detroit 2
Szladek, Frank J.....4045 W. Jefferson Ave., Ecorse 29
Szmigiel, Alex J.....20060 Kelly, East Detroit
Taber, Rodman E.....Henry Ford Hosp., Detroit 2
Tactac, Albert J.....15244 Middlebelt, Livonia
Talbot, Frank G.....1365 Cass, Detroit 26
Tallant, Edward J.....18041 Greenfield, Detroit 35
Talley, Robt. W.....Henry Ford Hosp., Detroit 2
Talmers, Fredk. N.....V.A. Hospital, Dearborn
Tamblyn, E. J. (L).....737 Marlborough, Detroit 15
Tanay, Emanuel.....861 Fisher Bldg., Detroit 2
Tanner, Natalia M.....8401 Woodward Ave., Detroit 2
Tapert, Julius C.....888 Chalmers Ave., Detroit 15
Tarpinian, Harry.....10955 Farmington Rd., Livonia
Tasker, Helen E.....76 W. Adams Ave., Detroit 26
Tassie, Ralph N. (L).....15000 Gratiot Ave., Detroit 5
Tatelis, Gabriel A.....1011 E. Grand Blvd., Detroit 7
Tatelman, Maurice.....1420 St. Antoine, Detroit 26
Taurence, Wm. H.....1860 Ford Ave., Wyandotte
Taylor, Ivan B.....30 N. Edgewood Dr., Grosse Pte. Shs.
Taylor, Nelson M.....215 Dean Lane, Grosse Pte. Pk. 36
Taylor, Richard A.....28 W. Adams St., Detroit 26
Taylor, Wm. V.....17200 E. Warren, Detroit 24
Tazzioli, Henry A.....21970 Moross Rd., Detroit 36
Tear, Malcolm, J. J.....862 W. McNichols Rd., Detroit 3
Teitelbaum, Myer.....18510 Meyers Road, Detroit 35
Tenaglia, Thos. A.....3180 Fort St., Lincoln Park
Teves, Manuel L.....13020 Mack Ave., Detroit 15
Texter, Elmer C. (L).....7457 Gratiot Ave., Detroit 13
Thal, Alan P.....687 Balfour, Detroit 36
Thomas, Alfred E.....73 E. Palmer, Detroit 2
Thomas, Blanche M.....6535 Allen Rd., Allen Park
Thomas, Leon D.....3019 West Warren, Detroit 8
Thomas, L. Murray..801 Dav. Whitney Bldg., Detroit 26
Thompson, Arthur L.....12632 Dexter, Detroit 38
Thompson, Hugh O.....6014 W. Fort St., Detroit 9
Thompson, Wm. A. (R).....12632 Dexter, Detroit 38
Thomson, Danl. C.....2934 Biddle Ave., Wyandotte
Thornell, Harold E.....2536 W. Grand Blvd., Detroit 8
Thornton, Jerry A.....525 Visger Rd., Ecorse 29
Thosteson, G. C.....1139 Dav. Whitney Bldg., Detroit 26
Thumann, Robt. C...20045 Mack Ave., Grosse Pte. Wds.
Thumim, Sadie.....15306 Joy Rd., Detroit 28
Timma, Richard J...16401 Grand River Ave., Detroit 27
Ting, Yoeh Ming.....16024 Stratford Dr., Southfield
Tkaczuk, Dmytro.....10345 Joseph Campau, Detroit 12
Toal, Robert E.....20953 Grand River, Detroit 19
Tobin, John S.....13400 W. Outer Dr., Detroit 28
Todoroff, Theodore G.....22146 Ford Rd., Dearborn 6
Tolbert, Vassal G.....3461 W. C. Chrysler Exp., Detroit 1
Tomsu, Chas. L. (L).....16521 Westmoreland Rd., Detroit 19
Torp, Raymond T.....660 Cadieux Rd., Grosse Pte. 30
Torres, Estelle P.....3985 Caniff, Hamtramck 12
Torres, Raul M., Jr.....3985 Caniff St., Hamtramck 12
Tourkow, Lawrence P...3290 Sherbourne Rd., Detroit 21
Tourney, Garfield.....Lafayette Clinic, Detroit 7
Townsend, Frank M., Jr.....1055 Trumbull, Detroit 16
Tracey, John M.....15317 W. McNichols, Detroit 35
Tracy, Edward G.....3411 Evaline St., Detroit 12
Trader, Kenneth N.....3001 W. Grand Blvd., Detroit 2
Treisman, E. J.....15105 W. 7 Mile Rd., Detroit
Tremain, Harold L.....15475 Ashton, Detroit 23
Triska, Franz K.....12444 E. 7 Mile Rd., Detroit 5
Troester, Geo. A.....81 E. Kirby, Detroit 2
Trombino, James F. V...8625 Marygrove Dr., Detroit 21
Trotsky, Martin B.....7411 Third Ave., Detroit 2
Truba, Paul K.....3714 W. McNichols Rd., Detroit 21
Trudgen, Paul E.....1224 Beechmont, Dearborn
Trunsky, Ronald E.....Sinai Hospital, Detroit 35
Trupiano, Samuel....420 Eastland Prof. Bldg., Detroit 36
Trythall, S. W.....Box 33, Orchard Lake
Tseng, George T. C.....Annapolis Hospital, Wayne
Tulloch, John.....1040 David Whitney Bldg., Detroit 26
Tupper, Roy D. (L)....15101 W. 7 Mile Rd., Detroit 19
Turbett, Claude W. (L).....4230 Commonwealth Ave., Detroit 8
Turcotte, Vincent J. (A).....545 Lakeland, Grosse Pte.
Turkel, Henry.....8000 W. 7 Mile Rd., Detroit 21
Turnbull, Jack V.....22340 Michigan Ave., Dearborn
Turner, Edward T.....5050 Joy Rd., Detroit 4
Turner, Rachel E.....3113 Evergreen, Royal Oak
Turner, Robert R.....2841 Monroe Blvd., Dearborn
Tygart, Robert L.....Wayne Co. Gen. Hosp., Eloise
Uddyback, Odie T. (A).....Northville State Hosp., Northville
Ujda, Chester J.....32126 Woodbrook, Wayne
Ulmer, Arthur A.....1989 Broadstone, Detroit 36
Ulrich, Willis H.....22365 Grand River Ave., Detroit 19
Umphrey, Clarence E.....6216 Hill Dr., Birmingham
Unkefer, Wm. T.....15800 W. McNichols Rd., Detroit 35
Usher, Wm. K.....15605 Kercheval Ave., Grosse Pte. 30
Usndek, Harold E.....18485 Mack Ave., Detroit 36
Vaitas, Otonas.....11445 Harrison Ave., Livonia
Vaitkevicius, V.....4811 John R St., Detroit 1
Vale, Clair F. (R)..2615 Via Tuscany, Winter Park, Fla.
Van Arsdale, Wm. L. (A).....APO 301 S DA Mission, San Francisco, Calif.
Van Beecelaere, L. A.....15830 Fort, Southgate
Vanden Berg, H. J., Jr.....1553 Woodward Ave., Detroit 26
Vander, Seymour A.....12730 W. McNichols Rd., Detroit 35
Van Eck, James E.....1716 E. Grand Blvd., Detroit 11
Van Hoek, Donald E.....20323 Mack, Grosse Pte. Woods
Van Raaphorst, L. F.....861 Monroe, Dearborn
Van Slyck, E. J.....Henry Ford Hospital, Detroit 2
Vanvalzah, Henry J.....Ford Motor Co., Miller Rd., Dearborn
Vardon, Edward M.....12897 Woodward Ave., Highland Park 3
Vasu, Vasile O.....4829 Woodward Ave., Detroit 1
Veling, William F.....3001 W. Grand Blvd., Detroit 2
Vera, Ramon W.....106 W. Davison, Highland Park 3
Vincent, Charles C.....2424 Puritan, Detroit 38

Vincent, John W.....22214 Ford Rd., Dearborn
Vipond, Wm. S.....15398 Gratiot Ave., Detroit 5
Viscomi, Geo. J.....2021 Monroe, Dearborn
Visscher, Donald W.....12922 W. Warren, Dearborn
Vokes, Milton D. (L).....10182 Gratiot Ave., Detroit 13
Vonder Heide, Elmore C...17190 Strathmoor, Detroit 35
Vorwald, Arthur J.....1401 Rivard St., Detroit 7
Vossler, Albert E.....1553 Woodward Ave., Detroit 26
Waehneldt, Niels R.....Henry Ford Hospital, Detroit 2
Waggoner, Lyle G...404 David Whitney Bldg., Detroit 26
Wainger, Max J.....15105 W. 7 Mile Rd., Detroit 35
Wainstock, Michael A.....621 David Whitney Bldg., Detroit 26
Wakeman, Everal M.....23100 Cherry Hill, Dearborn
Waldbott, Geo. L.....2930 W. Grand Blvd., Detroit 2
Walker, Frank B., II....1305 Berkshire Rd., Grosse Pointe
Walker, Geo. L.....7815 E. Jefferson Ave., Detroit 14
Walkowiak, Robt. G.....76 W. Adams Ave., Detroit 26
Wallace, Silas W. (L)..7815 E. Jefferson Ave., Detroit 14
Waller, John P.....25447 Plymouth, Detroit 39
Walls, Arch 116 Cretline, Kalispell, Montana
Walser, Howard C.....459 Fisher Bldg., Detroit 2
Walsh, Francis P.....654 Fisher Bldg., Detroit 2
Walt, Alexander J.....Detroit Receiving Hosp., Detroit 26
Walter, Arthur W.....14201 Rutland Rd., Detroit 27
Walter, Floyd J.....18714 Grand River Ave., Detroit 23
Wang, Chun Heng H.....25500 Edgemont, Southfield
Wang, Joy Ya Hsiang.....35550 Michigan, Wayne
Warner, Jack F.....4811 W. Outer Dr., Detroit 35
Warner, Peter L. (L)....15320 Artesian Ave., Detroit 23
Warren, Bernice K.....18984 Livernois, Detroit 21
Warren, Irving A.....18984 Livernois, Detroit 21
Warren, Max W.....20001 Shrewsbury St., Detroit 21
Warren, Wadsworth (A).....415 Burns Dr., Detroit 14
Wasserman, Harold.....19001 W. 7 Mile Rd., Detroit 19
Wassermann, Lewis C.....300 W. McNichols Rd., Highland Park 3
Waszak, Chas. J.....2501 W. Grand Blvd., Detroit 8
Waters, William L.....19203 Grand River, Detroit 23
Watson, Harwood G.....935 S. Military Ave., Dearborn
Watson, James E., Jr.....18524 Grand River, Detroit 23
Watts, Fredk. B.....16321 Mack Ave., Detroit 24
Watts, John C.....7360 12th St., Detroit
Watts, Jos. C.....742 Maccabees Bldg., Detroit 2
Wayne, Morris A.....15930 Livernois Ave., Detroit 38
Weaver, Clarence E. (R).....1260 S.E. Fourth Ct., Deerfield Beach, Fla.
Weaver, Delmar F.....1100 Bishop, Detroit 30
Weber, Karl W.....18101 E. Warren Ave., Detroit 24
Webster, John E. (A).....47 Pine Court, Detroit 36
Wechsler, Norman.....18400 Schaefer Hwy., Detroit 35
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Weed, Milton R...1059 Berkshire Rd., Grosse Pte. Pk. 30
Wehenkel, Albert M. (L).....7356 12th St., Detroit 6
Wehr, Maurice B.....2355 Fort St., Lincoln Park
Weiksnar, John F.....1800 Tuxedo, Detroit 6
Weiner, Allen D.....21415 W. 8 Mile Rd., Detroit 19
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Weingarden, David (L).....13240 Vassar Dr., Detroit 35
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Weisenthal, Irvin I.....5764 Woodward Ave., Detroit 2
Weiss, Casimir P.....1801 E. Canfield, Detroit 7
Weiss, Morris.....Hawthorn Center, Northville
Weissman, Fredrick.....20905 Greenfield Rd., Southfield
Welch, John H.....18550 W. Outer Dr., Dearborn 7
Weller, Chas. N. (R).....1973 N.E. 3rd St., Deerfield Beach, Fla.
Wells, Herschel J.....Wayne Co. Gen. Hosp., Eloise
Wells, Martha L.....760 Fisher Bldg., Detroit 2
Weltman, Carl G. (A).....Rt. 2, Snead Island, Palmetto, Fla.
Wendt, Vernon E.....Det. Receiving Hospital, Detroit 26
Wenokur, Milford E.....20441 James Couzens Hwy., Detroit 35
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Whitehead, Walter K...1553 Woodward Ave., Detroit 26
Whitehouse, Fred W.....2799 W. Grand Blvd., Detroit 2
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Willard, Rodney E.....22231 W. Outer Dr., Dearborn
Williams, Clarence J.....1342 Grayton Rd., Grosse Pte. 30
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Witus, Morris.....18984 Livernois, Detroit 21
Wizer, Mary B. G...13345 W. McNichols Rd., Detroit 35
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Wolfe, John N.....432 E. Hancock, Detroit 1
Wolfe, Max O.....7-260 Gen. Motors Bldg., Detroit 2
Wolfson, Wm. Q.....3000 Seminole, Detroit 14
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Yarrows, Morton I.....455 Medbury St., Detroit 2
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Yesayian, H. G.....609 Kales Bldg., Detroit 26
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Young, Irving I.....32280 Shrewsbury, Farmington
Young, M. O. 8445 E. Jefferson, Detroit 14
Young, Richard D.....18000 James Couzens Hwy., Detroit 35
Young, Viola M. (L).....10 Peterboro St., Detroit 1
Young, Watson A.....43691 Expressway, Belleville
Youngstrom, Clarence S.....8004 Lochdale, Dearborn

Zabinski, Edward J.....585 Ballantyne Rd., Detroit 36
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Zane, Alan Irving (A).....Receiving Hospital, Detroit
Zara, Sabah E.....15830 Fort, Southgate
Zavell, Paul M.....1932 Broadstone, Grosse Pte. Woods
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Zolliker, Margaret Z.....21327 Harper Ave., St. Clair Shores
Zubroff, L. S.....752 Fisher Bldg., Detroit 2
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Cardinal, Thos. H.....212 S. Simons, Cadillac
Daugharty, Robt. V.....107 N. Mitchell, Cadillac
Inman, John C.....Lake City
Kilmer, David N.....222 Howard St., Cadillac
Mills, Georgia.....Lake City
Moon, Wm. W.....826 Oak St., Cadillac
Moore, G. P.....107½ N. Mitchell, Cadillac
Norton, R. C.....706 Lincoln St., Cadillac
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Posthuma, Millard.....124 E. Cass St., Cadillac
Richmond, Thomas F.....308 S. Shelby, Cadillac
Sanderson, James M.....512 Chapin, Cadillac
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Johnson, Donald E.....211 E. Court St., Flint 3
Upjohn, Lawrence N., M.D.....301 Henrietta St., Kalamazoo

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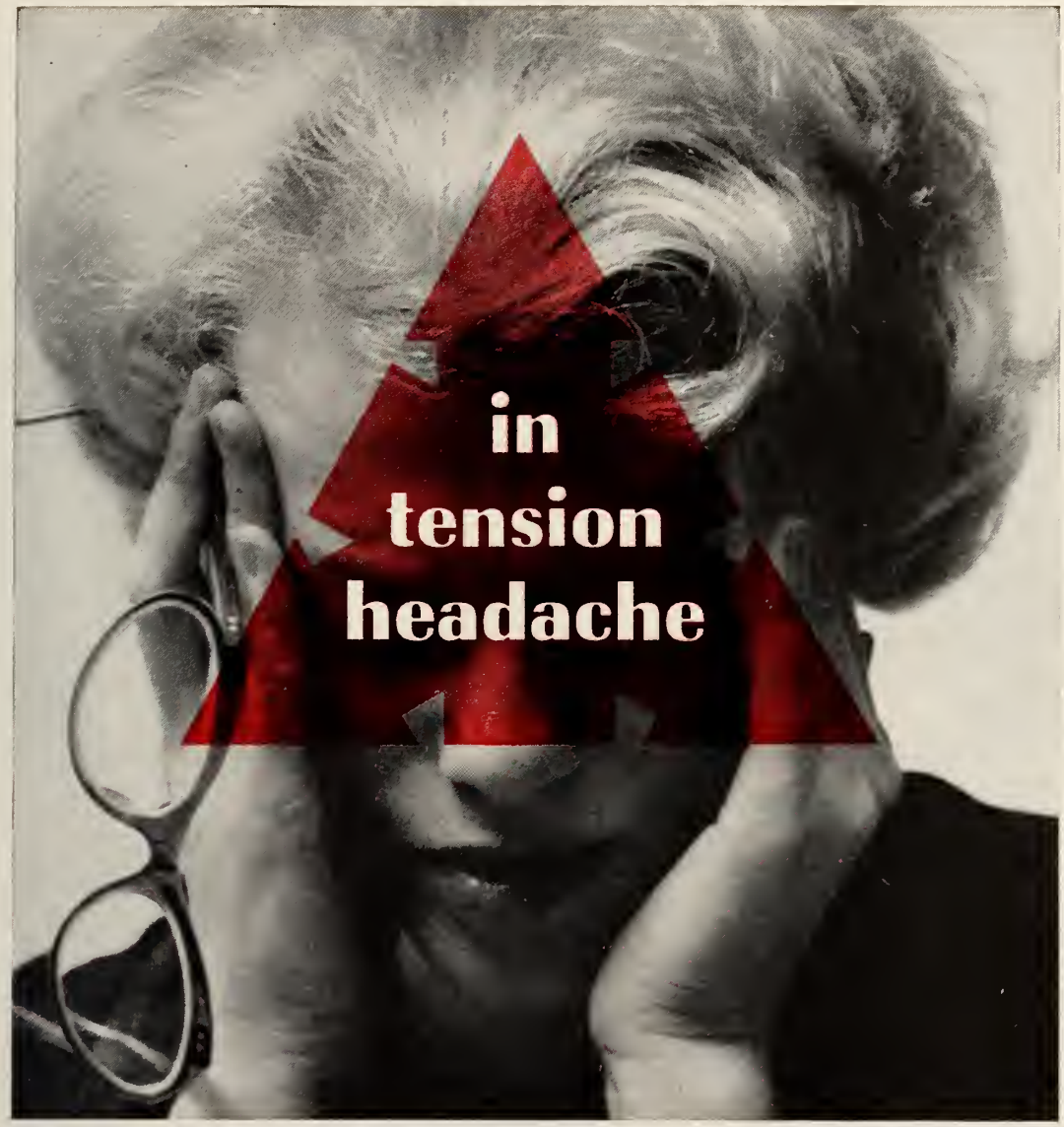
DELEGATES TO A. M. A.

Delegates

	Term Expires
J. R. Heidenreich, M.D., Daggett	1963
W. A. Hyland, M.D., *Chairman*, Grand Rapids	1963
O. J. Johnson, M.D., Bay City	1963
L. R. Leader, M.D., Birmingham	1963
C. I. Owen, M.D., Detroit	1964
G. W. Slagle, M.D., Battle Creek	1964
D. N. Sweeny, Jr., M.D., Detroit	1964

Alternates

	Term Expires
G. B. Saltonstall, M.D., Charlevoix	1963
J. M. Wellman, M.D., Lansing	1963
Sidney Adler, M.D., Detroit	1963
B. M. Harris, M.D., Ypsilanti	1963
R. E. Rice, M.D., Greenville	1964
A. Hazen Price, M.D., Detroit	1964
E. E. Martmer, M.D., Grosse Pte	1964



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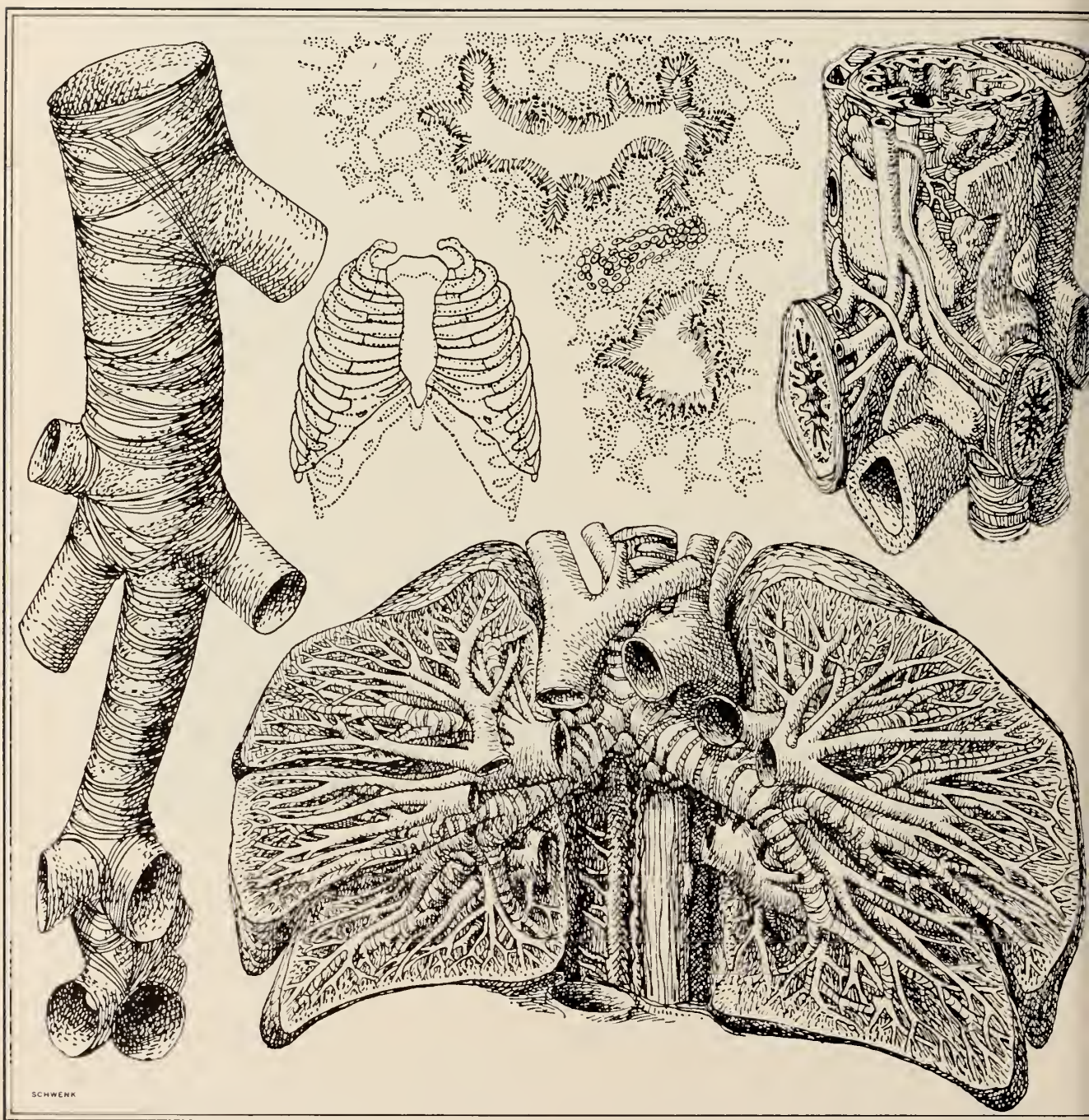
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*TRADEMARK

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With ARISTOCORT Triamcinolone, many asthmatic patients obtain early gratifying relief of wheezing, dyspnea and spasmodic coughing. And maintenance dosage in many cases can be surprisingly low—*often as little as a single 2 mg. tablet per day.* Yet it provides this symptomatic control—which may enable many patients to continue their customary livelihoods or regular household activities—with only minimal interference with other metabolic functions. In this respect, ARISTOCORT Triamcinolone is distinguished compared with other corticosteroids, old and new. Typical steroid problems of sodium retention and edema, euphoria, or voracious appetite and excessive weight gain rarely occur.

ARISTOCORT Triamcinolone is indicated when anti-inflammatory, anti-allergic action of glucocorticoids is desired. SIDE EFFECTS of glucocorticoids generally: Cushingoid effects, hirsutism, leucopenia, purpura, vertigo, fatigue, increased hyperglycemia, osteoporosis, gastrointestinal hemorrhage, cataracts, growth suppression in children and increased intracranial pressure. Other glucocorticoid effects thought more likely to occur with triamcinolone: reversible weakness of muscles and flushing of face.

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FORMULA—Tablets (scored) containing 1 mg., 2 mg. or 4 mg. of triamcinolone. Syrup —2 mg. of triamcinolone diacetate per 5 cc. (5 mg. of triamcinolone diacetate is equivalent to 4 mg. of triamcinolone).

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President's Page

CHANGE

"In this world of change naught which comes stays and naught which goes is lost."—MAD. SWETCHINE.



Clarence D. Owen

President

Michigan State Medical Society

All through time we have seen each passing year bring new faces, new ideas, new plans to replace old ones.

Usually, although not always, new things are better and civilization progresses.

I know that Doctor Johnson will do an outstandingly fine job as your President in 1963-64. He has demonstrated his devotion and his wisdom in his service on The Council and as President-Elect. The same is true I am sure for the others who will serve as elected officers with him. I wish them God-speed.

The work of the official family, the House of Delegates and The Council, the committees and the individual physicians is vitally important to our profession's future. But the machinery that carries out the policies of the various forces, including our profession, that shape civilization's destiny is also important.

We live in a complex society, and the scientific, economic, sociological, educational and governmental intricacies that make up an active progressive association are phenomenal. Only full time career people trained in administration can keep on top of the problems and pressures that confront us.

For this reason the departure of William J. Burns ranks of major importance. He has done a brilliant job for us. Now, we have a new team headed by Hugh W. Brenneman. Hugh was chosen carefully 17 years ago to be our Public Relations Counsel. He was chosen equally carefully to carry on as Executive Director. We know he is intensely loyal and has proven that he is capable of top administrative leadership.

Perhaps equally conducive to an even greater future for the Society is the team that will be working with Hugh. It is experienced, hardworking, capable and devoted. There is only one new face in this administrative family—that of our Editor—and we know him well as a fine educator. And don't forget the other fine career people who make up that family —a truly remarkable aggregation of talent!

Change there always will be. We who watch and participate in that change as your representatives within the profession ask your support for your new teams—official and executive alike. We are confident it will be forthcoming in full measure.

Hugh W. Brenneman To Succeed Wm. J. Burns

In unanimous action, the MSMS Council has appointed Hugh W. Brenneman to succeed William J. Burns as the Executive Director of the Michigan State Medical Society in 1964.

The action was taken at the July Council meeting and "was taken in sufficient time to permit adequate arrangements for the transfer of duties to be consummated," according to MSMS President Clarence I. Owen, M.D.

The MSMS Council also has appointed Warren F. Tryloff to the position of Associate Executive Director.

Two other appointments at the same time were Charles J. Tupper, M.D., Ann Arbor, as Editor of THE JOURNAL MSMS to succeed Wilfrid Haughey, M.D., who died July 12; and Herbert A. Auer to the position as Managing Editor of THE JOURNAL.

Full biographic material about the four men was sent to every MSMS member in August.

Mr. Brenneman has served as Public Relations Counsel of MSMS since 1946 and subsequently was named Assistant Administrator. Before joining MSMS, he had been a teacher, high school principal, radio network commentator and U. S. Naval officer. He has served as Secretary of the Michigan Health Council, Executive Director of the Michigan Association of the Professions; and was instrumental in the organization of the Michigan Heart Association, Public Relations Association of Michigan and other organizations. Hugh has earned an outstanding reputation as a public relations administrator and effective speaker.

* * *

MR. BURNS WILL RETIRE—to—a new job conducting his own business as a medical convention and exhibition director. He and Jo Burns will winter in Fort Lauderdale and summer in Michigan. He has been Executive Director of MSMS for almost 29 years and has made thousands of friendships both in Michigan and elsewhere as the efficient Society's administrator.

Mr. Burns has a long list of accomplishments—as the first secretary of the Michigan Medical Service, the first secretary of the



Wm. J. Burns, LL.B.



Hugh W. Brenneman



Warren F. Tryloff

Michigan Health Council, et cetera. National recognition was given him in 1960 by the American Society of Association Executives as the "Outstanding Executive of a State Association."

* * *

MR. TRYLOFF CAME TO the MSMS in 1954 from the Michigan Health Council. He served as the Public Relations Field Representative in charge of the Detroit office, then as Associate Public Relations Counsel, and in 1959 was named Assistant to the Executive Director. Secretary of the Michigan Foundation for Medical and Health Education, he will serve as General Chairman of Arrangements for the 1964 Joint Conference on Medical Conventions in Detroit.

DOCTOR TUPPER, a graduate of the University of Nebraska Medical College, is President-Elect of the Washtenaw County Medical Society and Associate Dean of the University of Michigan Medical School. His curriculum vitae is proof of his broad interests in medicine and its organizational as well as scientific aspects.

MR. AUER has served as THE JOURNAL production co-ordinator, Public Relations Field Secretary and MSMS committee secretary since joining MSMS in 1959. He is a former teacher, former newspaperman and a former Michigan State University editor.



Charles J. Tupper, M.D.



Herbert A. Auer

Speaks in "Thumb"

MSMS President C. I. Owen, M.D., spoke to the Sanilac County Medical Society recently on the subject, "The Future of Medicine." Participating also in the meeting were members of the St. Clair, Huron and Lapeer County Medical societies.

M. A. Darling, M.D., Dies; MSMS Past President

Milton A. Darling, M.D., 73, Detroit physician since 1916 and a past president of the Michigan State Medical Society, died July 30, 1963.



M. A. Darling, M.D.

Doctor Darling served as president in 1959-60. He was a past president also of Wayne County Medical Society and of the Detroit Institute for Cancer Research.

William J. Stapleton, Jr., M.D., paid tribute to Doctor Darling in the *Detroit Medical News* as follows:

"Milton Darling was a kindly and genial man, easy to approach with problems, never in too great a hurry to answer questions and always ready with encouragement for the younger physician. There was one facet of the doctor's character which appealed especially to me. He was a strong advocate of better understanding between doctor and patient. Once he said, 'Most individual criticism of physicians is directly traceable to misinterpretation of statements made too hastily.'"

These attributes which characterized him as a master of the art of medicine endeared him to the entire profession and made him one of the most popular of MSMS presidents.

A native of Branch County, Doctor Darling's first ambition was to become a dentist. He graduated in 1911 from the University of Michigan School of Dentistry. He then entered the U-M medical school and completed that course in 1914.

Doctor Darling remained in Ann Arbor until 1916 for postgraduate training in surgery, obstetrics and gynecology. Then he joined the Grace Hospital staff where he remained during his professional career.

He was a Fellow of the American College of Surgeons, a Diplomate of the American Board of Obstetrics and Gynecology, a member of the Detroit Surgical Society and the Academy of Surgery of Detroit and many other medical organizations.

Science Service, in selecting the ten top advances in science in 1962, listed as Number 2 the "immunization against malaria by a single injection of a chemical CI-501."

* * *

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In a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, distilled water, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax and 0.25% methylparaben as preservative.

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Ingredients: Each gram contains: 'Aerosporin'® brand Polymyxin B Sulfate 5,000 Units; Zinc Bacitracin 400 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base).

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County, State-Wide Workshops Held by MSMS Medical Socio-Economics Committee

Long range planning activities started by the MSMS Committee on Medical Socio-Economics this year featured sponsorship of a series of workshops in selected counties.

These workshops were designed to obtain physician "grass-roots" opinions on various critical medical socio-economic issues facing private medicine today. The county workshops culminated in a statewide workshop at MSMS Headquarters in East Lansing. Participants were representatives from component and specialty societies having medical socio-economic committees. After orientation by Harold F. Falls, M.D., of Ann Arbor, Chairman, MSMS Committee on Medical Socio-Economics and Clyde T. Hardwick, Ph.D., of Detroit, MSMS Economic Consultant, participants were divided into small discussion groups with each group exploring one or two subject areas such as medical education, voluntary health insurance, public health, nursing, paramedical personnel, et cetera. Members of the MSMS Committee on Medical Socio-Economics acted as discussion leaders with members of the MSMS Executive Staff serving as recorders.

The findings of this statewide workshop, as well as those of the previously held county workshops, will prove helpful as resource material for other state society committees.



Clyde T. Hardwick, Ph.D., MSMS Economic Consultant, briefs the participants at the state-wide Medical Socio-Economics Workshop held at MSMS Headquarters.



During a group discussion at the MSMS Socio-Medical Socio-Economics Workshop, Warren Tryloff, of the MSMS executive office staff, records the comments made by the participants.



Visual aids helped the discussion groups at the workshop. The recorder for this group was Richard Campau, standing, MSMS research director.



The views of physicians about nursing and para-medical personnel were expressed during this group discussion at the state-wide conference.



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3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain...not the patient").*

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HIGHLIGHTS of The Council

Midsummer Meeting, July 19-20, 1963

Ninety-nine items were discussed by The Council at its July meeting. Chief in importance were:

- Passing of Wilfrid Haughey, M.D. The Council opened its meeting with a period of silence in memory of Wilfrid Haughey, M.D., Editor of THE JOURNAL of the Michigan State Medical Society for 22 years, who died on July 12, 1963.

- Report of Michigan Delegation to AMA House of Delegates, June 1963 Atlantic City meeting, was presented by Chairman Wm. A. Hyland, M.D., of Grand Rapids and referred to the Editor for publication in JMSMS.

- Congratulations were extended to A. E. Heustis, M.D., on his reappointment as Michigan Commissioner of Health (fifth term).

- Committee reports were presented as follows:

 (a) Ad Hoc Committee to Survey Utilization of Health Insurance, meeting on April 17, reviewed work of Committee and authorized development of a statement of principles on proper utilization of modern medical care personnel and facilities.

 (b) Cancer Control Committee on May 9 discussed uniform method of reporting positive and negative smears, reference cards on cancer, cancer legislation, new policy of JMSMS Publication Committee and future plans of the Cancer Control Committee.

 (c) Medical Care Insurance Committee on July 11 held interviews with UAW representatives.

 (d) Committee on Rural Medical Service on May 22 reviewed the M.D. placement program of the Michigan Health Council, a possible health manpower survey by the Michigan Health Council, recommendations re analyzing health insurance policies for patients (which last item was re-referred by The Council to the Committee for further study and consultation with Legal Counsel Lester P. Dodd of Detroit).

 (e) Committee on Maternal Health on May 23 reviewed progress in development of desk reference cards for maternal health, the proposed 1964 Maternal Health Seminar, the current perinatal mortality rates, and subcommittee reports of maternal mortality, perinatal mortality, and lay education.

 (f) Committee to Study Establishment of Loan Fund for New Physicians on May 29 reviewed results of the Committee's survey of new physicians and other MSMS members who had views or recommendations regarding the need for establishment of a loan fund which the Committee thought was not necessary or practical at this time; the Committee suggested several ways that the MSMS and component societies could help new physicians.

 (g) Committee on Medical Socio-Economics on June 5 reviewed program discussion held immediately prior to the Economic Workshop of component and specialty society economic committees held at MSMS headquarters on June 5.

 (h) Committee on Alcoholism and Drug Addiction on June 12 reviewed progress in developing material for JMSMS Number on "Alcoholism," discussed organization of state government under new Constitution, reviewed annual report of the Committee, and discussed different programs on alcoholism in the state of Michigan.

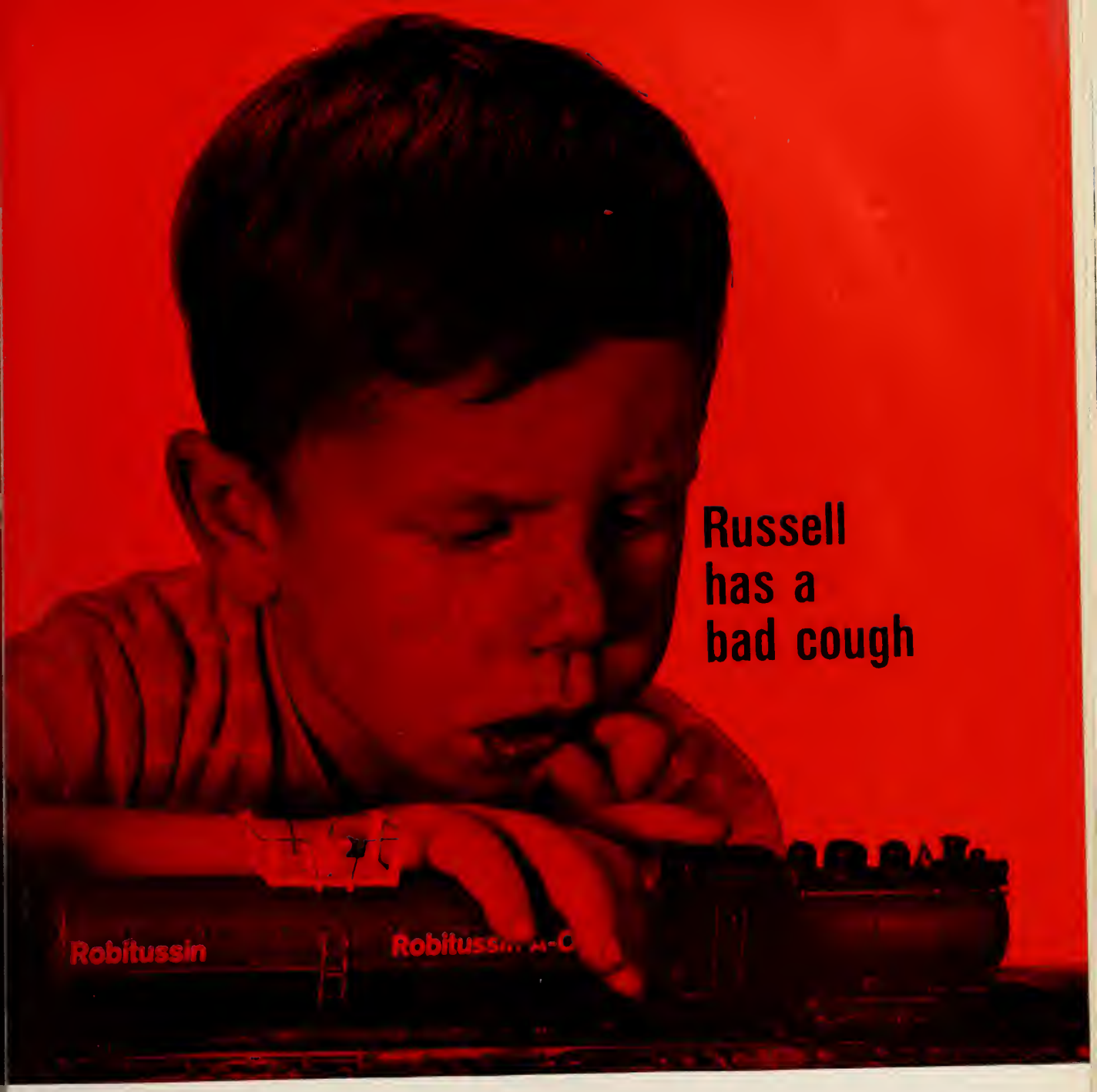
 (i) Committee on Professional Insurance Plans on June 19 reviewed merger of MSMS and Wayne County Medical Society group policies for sickness and accident (the Committee recommended favorable consideration of the new combined disability plan); high limit personal accident insurance; major medical proposals by Health Services, Inc., Medical Indemnity of America, and Michigan Medical Service; and Blue Cross-Blue Shield coverage of widows of MSMS members.

 (j) Liaison Committee with Michigan Association of Osteopathic Physicians and Surgeons on June 19 considered reports of discussions on Blue Cross-Blue Shield, the Peoples Community Hospital Authority, the matter of joint staff hospitals, the possibility of a single licensing practice act, and the proposed state health department under the new Michigan Constitution.

 (k) Occupational Health Committee on July 2 reviewed a report of the Subcommittee on Small Plant Medical Services, a report on Workmen's Compensation, and report of the subcommittee designated to review occupational health articles appearing in *California Medicine*.

 (l) Scientific Radio and Television Committee on July 9 reviewed the 1962-63 program, and discussed plans for the year 1963-64; also recommended that panel-type programming should predominate in all future productions, and that written transcripts of

(Continued on Page 856)



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*Blanchard, K., and Ford, R. A.: Clin. Med., 3:961, 1956.

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HIGHLIGHTS OF THE COUNCIL MEETING

(Continued from Page 854)

broadcasts be discontinued because of the difficulty in transcribing this type of presentation.

(m) Liaison Committee with State Executive Office on July 11 discussed a proposed meeting with the Governor and recommendations for appointments to be made by the Governor, and reviewed plans for reorganization of state government. (The Council instructed that nominations to the Michigan State Board of Registration in Medicine be transmitted to the Governor, per law authorizing MSMS to make these nominations).

(n) Advisory Committee to Coordinator of Centennial on July 18 reviewed details of 1965 MSMS Centennial to be held in Detroit and recommendations to implement these proposals. The Committee recommended that plans for the 1965 Michigan Health Fair be referred to the Chairman of Arrangements, Don W. McLean, M.D., of Detroit. (The Council voted that the 1965 Michigan Health Fair proposal be submitted to the House of Delegates as a special order of business).

- Standing Committees of The Council:

1. Report of Finance Committee meeting of July 18 included monthly financial statement, bills payable, brief of budget estimates vs. income and expenses for period December 1, 1962 through June 30, 1963, approval of proposed paragraph on "Finance" for Annual Report of The Council, funds to administer Rheumatic Fever Centers in 1964, study of travel accident insurance for MSMS officers and employees, plans for 1964 Michigan Clinical Institute, and retirement date of Executive Director Wm. J. Burns.

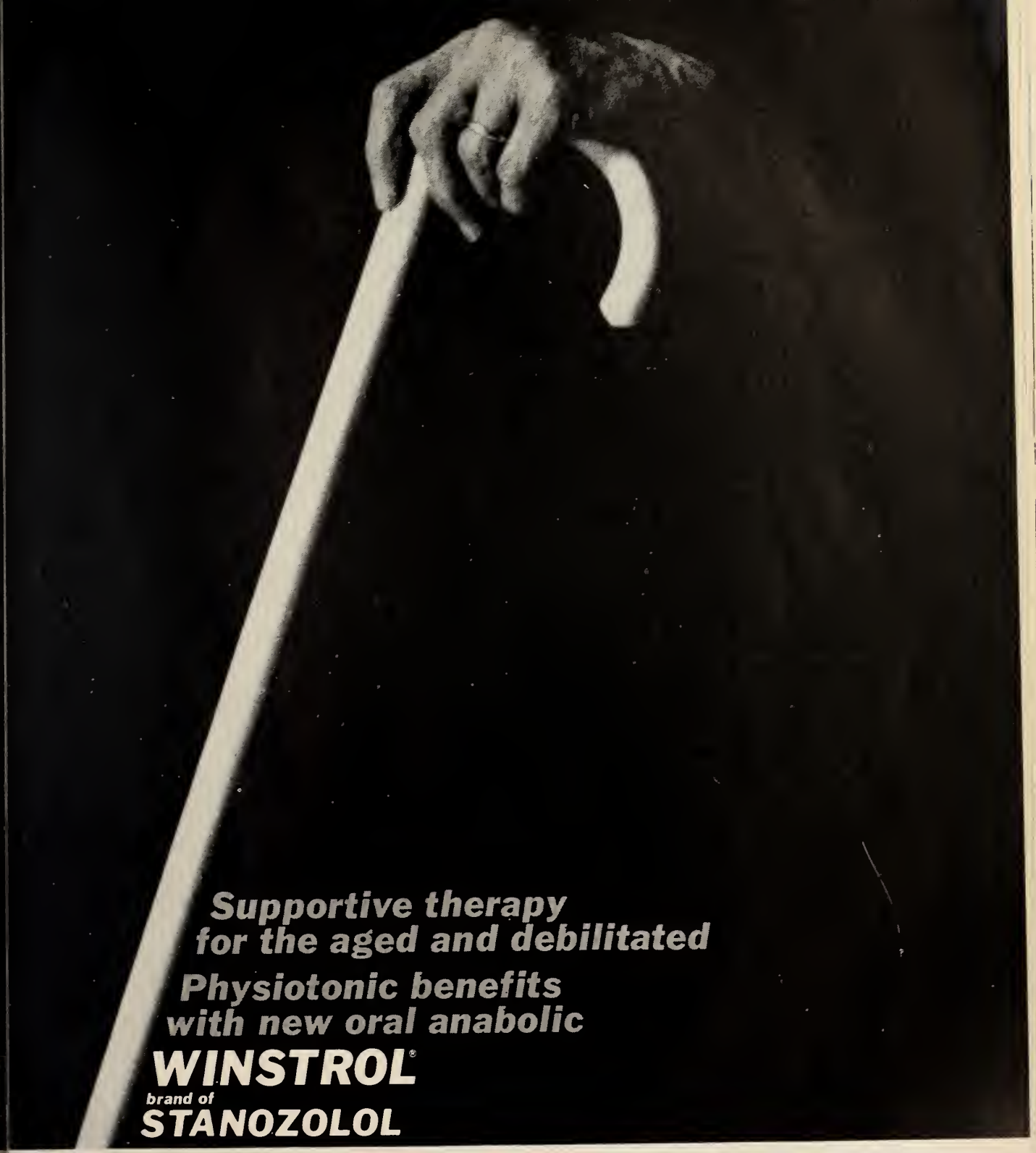
2. Report of Publication Committee meeting of July 18 included proposed paragraph on "THE JOURNAL" in Annual Report of The Council, progress report on journal production, report on journal advertising, appointment of Michigan advertising representative, job descriptions for the Scientific Editor and Managing Editor, series of articles on MSMS Centennial, progress report from Bruce Publishing Company from Messrs. Wm. C. Coulter and J. R. Bruce of St. Paul. Also discussed were representatives to Biennial Conference of State Medical Journal Advertising Bureau, recommendation to The Council that C. J. Tupper, M.D., of Ann Arbor be offered position as Scientific Editor of JMSMS for one year, beginning August 1, 1963.

3. Report of County Societies Committee of July 18 included approval to continue Cornell University Automotive Crash Injury Research Program in Michigan, resolution to implement recommendation of AMA House of Delegates' study of relationship of physicians not in private practice to organized medicine, nomination of the late Frederick G. Novy, M.D., as Michigan's outstanding medical man for submission to Postgraduate Medicine (the magazine), consideration of policy of insistence upon contribution by physician to certain hospital building funds as condition to being accorded staff privileges. (The Council action was "that MSMS affirm the AMA statement re the proper relationship of hospital privileges to hospital building contributions, and further that MSMS state that when a hospital says to a doctor 'we must obtain pledges from all physicians who will be using the hospital actively and desire priority of admitting privileges,' it is saying in effect 'the extent of your privileges will depend upon your dollar pledges rather than upon your skill and qualifications,' and that this type of coercion is abhorrent and indefensible.";

The County Societies Committee also considered the AMA position on "Public Health in Relation to Private Practice of Medicine," adopted by AMA House of Delegates in November, 1962; and Michigan Crippled Children Commission action re elective procedures under the Afflicted Children's Act (The Council's motion was "that we recommend to MCCC that it reconsider its instructions as carried in its letter to MCCC Medical Coordinators June 21, 1963 to provide for a policy in regard to the subject 'elective procedures' that individual physicians functioning in accredited hospitals with the approval of Hospital Qualifying Committee be permitted to carry on elective procedures designated by MCCC under the Afflicted Children's Act and do so without further consultation than that normally required by the approved hospitals, and be it further known that MSMS offers its advice and help to MCCC in future situations which the Commission might consider to be inadequately handled by the medical profession."

- Official Hosts at the MSMS Reception for Michigan Health Officers Association were selected: C. I. Owen, M.D., O. J. Johnson, M.D., O. K. Engelke, M.D., R. V. Daugharty, M.D., J. J. Lightbody, M.D., and John J. Coury, M.D.
- David A. Bowman, M.D., of Bay City, Councilor of the Tenth District, announced his resignation as he is leaving Bay City to take a year's training in psychosomatic medicine at Menninger Foundation in Topeka, Kansas. Doctor Bowman's resignation was accepted with sincere regret. His successor will be appointed by the House of Delegates in September.
- The Council accepted the invitation of the Michigan Society of Mental Health to co-sponsor the Mental Health State Leadership Conference to be held in Lansing October 1.
- Committee Appointments: Luther R. Leader, M.D.,

(Continued on Page 858)



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rked improvement in appetite / Measurable weight gain Winthrop

HIGHLIGHTS OF THE COUNCIL MEETING

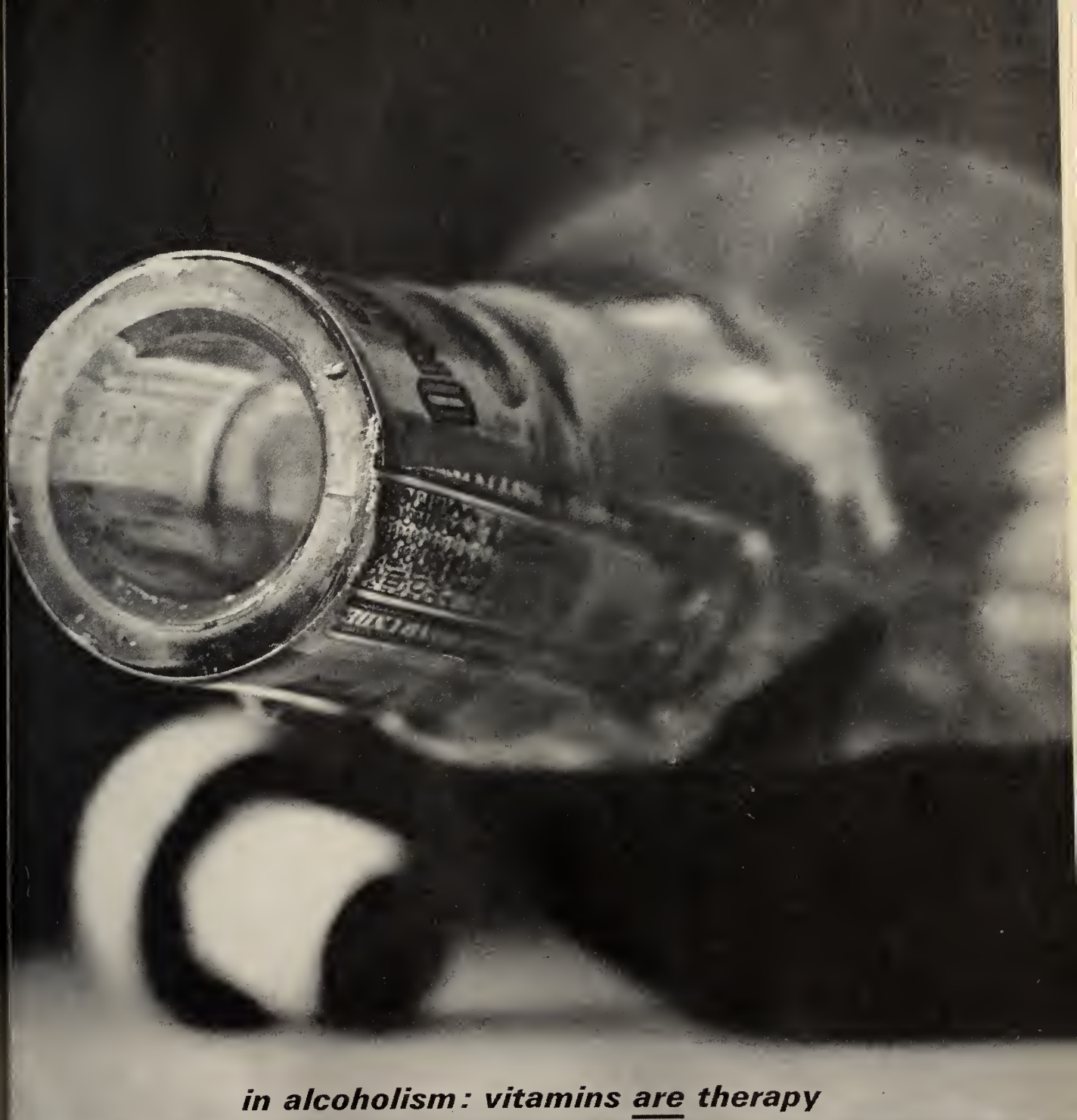
(Continued from Page 856)

Detroit, as Chairman of the Relative Value Study Committee; Richard L. Rapport, M.D., Flint, as Chairman of the Medicine and Religion Committee with W. C. Beets, M.D., Grand Rapids, Ralph R. Cooper, M.D., Detroit, R. A. Frary, M.D., Monroe, A. E. Heustis, M.D., Lansing, Donald V. Sargent, M.D., Saginaw, R. W. Teed, M.D., Ann Arbor, James R. Dehlin, M.D., Gladstone as members thereof; W. J. Jend, M.D., Detroit, Chairman of the Workmen's Compensation Study Committee, with the following members: D. L. Block, M.D., Detroit, Lester P. Dodd, Detroit, R. P. Lacy, Birmingham, and Robert Ralson, M.D., Lansing; Arrangements Committee 1965 Health Fair: Don W. McLean, M.D., Chairman with the following Vice-Chairmen —for Exhibits, C. P. Polentz, M.D., Southfield, for Publicity, D. N. Sweeny, Jr., M.D., Detroit, for School Participation, Remus G. Robinson, M.D., Detroit, for Exhibit Traffic, J. D. Fryfogle, M.D., Detroit, for Finance, L. R. Leader, M.D., Birmingham.

- President C. I. Owen described the important activities of the recent AMA House of Delegates session (Atlantic City, June 1963) and the work of Michigan Delegates on reference committees.
- President-Elect O. J. Johnson, M.D., presented his committee appointments for the year 1963-64 and asked for further suggestions, especially for names of young interested physicians who might be willing to make a contribution of time and talent to MSMS committee activity.
- Speaker J. J. Lightbody, M.D., stated that Governor George Romney had accepted the MSMS invitation to speak to the House of Delegates on Monday, September 23, at 11:00 a.m.; the Speaker further stated he would make some recommendations to the House of Delegates for changing the organization of the reference committees.
- Secretary D. Bruce Wiley, M.D., reviewed a letter from Michigan Hospital Service re required change in the composition of the MHS Board of Trustees which reduces the medical representatives to two after March 1964. The letter expressed appreciation to long term Trustees E. R. Elzinga, M.D., of Marquette and William M. LeFevre, M.D., of Muskegon.
- Council Chairman Oliver B. McGillicuddy, M.D., was authorized to appoint an ex-officio representative from MSMS to the Board of Directors of the Michigan Association for Health, Physical Education and Recreation.

Legal Counselor Lester P. Dodd presented opinions on criteria for staff bylaws governing sterilization; on liability of "attending physician" under varying circumstances for the acts or omissions in emergency room care; on who may legally consent to autopsies; on liability for emergency room mishaps and who may be jointly and/or severally liable.

- Executive Director Wm. J. Burns reported on staff activities since The Council's May 15 meeting which included fourteen meetings of staff section head; six weekly meetings of the entire staff; coverage of seventeen committee meetings and sixty-five other meetings throughout the state by staff personnel; on the medical socio-economic workshop held in Escanaba on May 24 and the statewide workshop in East Lansing on June 5. Mailings since May 15 total 24,962 pieces.
- Public Relations Counsel Hugh W. Brenneman reported on visits throughout the State re public relations and legislative activity, the new doctor-news media relations meetings in Berrien County, Genesee County, Muskegon County, and Oakland County; talks and television presentations; report of MSMS exhibit at the Kent County Health Fair, and plans for scientific news coverage of the 1963 Annual Session.
- Beaumont Memorial Foundation President Otto O. Beck, M.D., of Birmingham reported completion of the Beaumont Memorial Project on Mackinac Island with the installation of the fourth diorama. He recommended that now, since the project was complete, the Foundation be dissolved and its assets be transferred to MSMS, which recommendation was referred by The Council to the Finance Committee and Legal Counsel for study and report.
- The Council, in Executive Session, appointed Hugh W. Brenneman as Executive Director of MSMS to succeed retiring Wm. J. Burns, and Warren F. Tryloff as Associate Executive Director. The Council instructed that the membership be advised of these two appointments and also of the appointment of Doctor C. J. Tupper of Ann Arbor as Scientific Editor and Herbert A. Auer as Managing Editor of the MSMS JOURNAL.
- Matters of mutual interest were discussed with Michigan Medical Service President Sidney Adler, M.D., Deputy Frank Starr and MMS Legal Counsel Henry Sills.
- The annual joint meeting was held with the Board of Michigan Health Council represented by Gordon H. Scott, Ph.D., Sidney Chapin, M.D., L. G. Goodrich, E. L. Harmon, M.D., S. D. Steiner, M.D., J. A. Doherty and Leslie Harcus. Their presentations covered home care program, health careers recruitment, professional placement, radio and television, awards and health museum, and survey of MD-DO population by area location.



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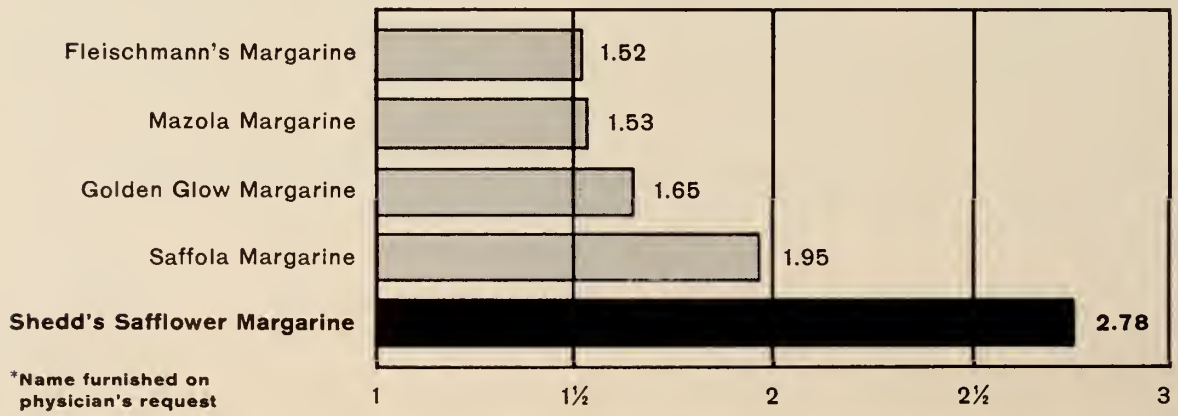


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An outstanding, independent research laboratory* was asked to compare five leading margarines for their proportions of beneficial poly-unsaturates to saturated fats. All samples were purchased at store level by shoppers for the research laboratory, and the results given are the average of two tests made on each margarine.

THE RESULTS OF THIS TEST PROVED SHEDD'S SAFFLOWER MARGARINE HAS A HIGHER RATIO OF POLY-UNSATURATES TO SATURATED FATS.



*Name furnished on physician's request

Shedd's Safflower Margarine Tastes Best, too!

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Say you saw it in the Journal of the Michigan State Medical Society



HOW TO BE SURE
your young patients get the aspirin dosage you want them to have

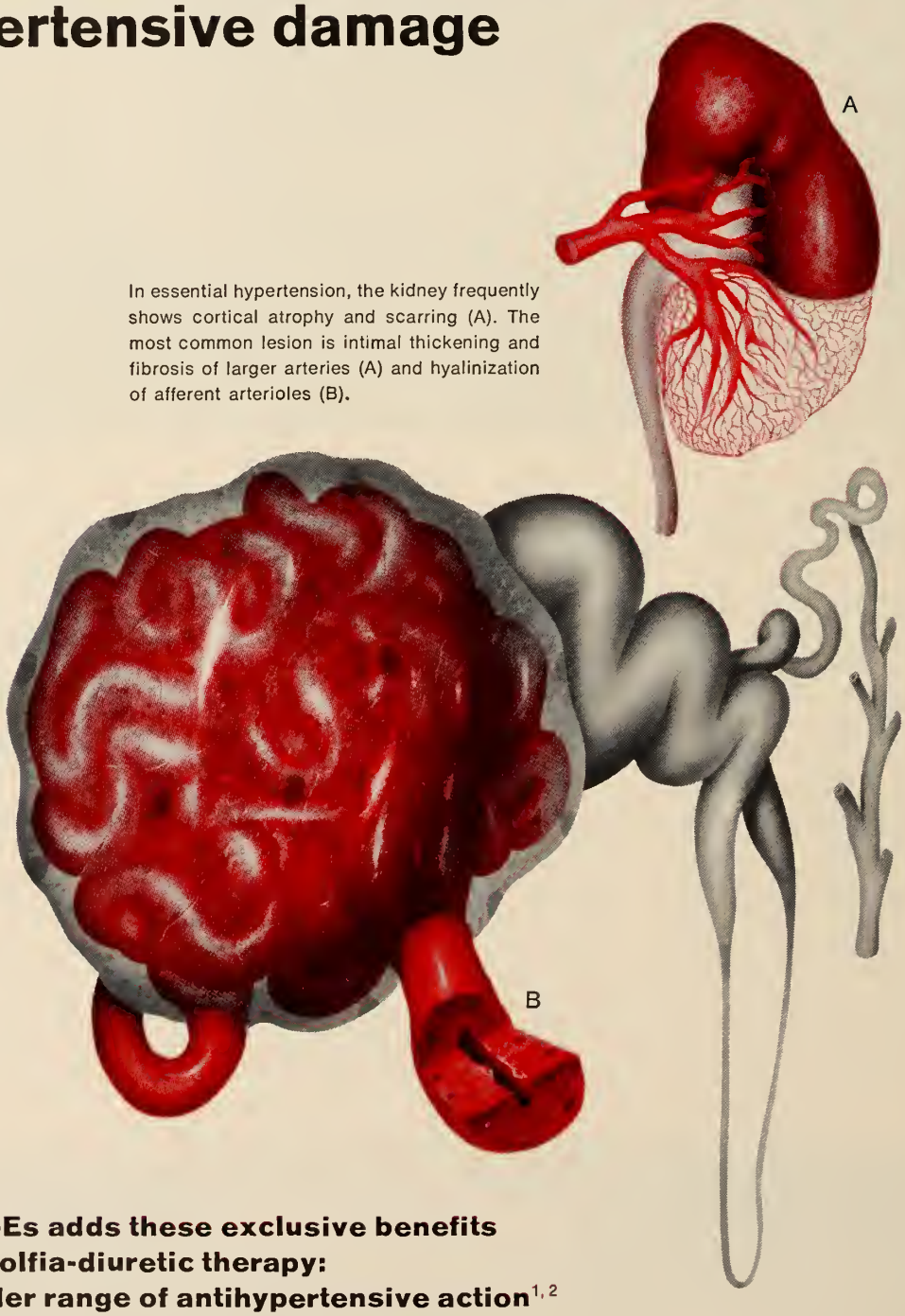
The answer is Orange Flavored Bayer Aspirin for Children

The dosage is 1¼ grains per tablet. Mothers place such confidence in the Bayer name. And the new orange flavor is so fresh and smooth that children take it readily. (The grip-tight cap on the bottle helps keep them from taking it on their own.)

For professional samples, just write The Bayer Company, Dept. 112, 1450 Broadway, New York 18, New York.



Ser-Ap-Es® can help prevent hypertensive damage



In essential hypertension, the kidney frequently shows cortical atrophy and scarring (A). The most common lesion is intimal thickening and fibrosis of larger arteries (A) and hyalinization of afferent arterioles (B).

Ser-Ap-Es adds these exclusive benefits to rauwolfia-diuretic therapy:

1. a wider range of antihypertensive action[1, 2]
2. increased blood flow to the kidney[3]
3. increased blood flow to the brain[4]

More certain control of blood pressure, less likelihood of complications with Ser-Ap-Es

Progressive vascular change, with ultimate damage to the heart, brain, and kidney (at left), can often be prevented by effectively treating high blood pressure. To do this, more and more physicians are turning to Ser-Ap-Es. Hobbs,[1] for instance, gave Ser-Ap-Es to 74 hypertensive patients and reduced diastolic pressure to 90 mm. Hg or less in 84 per cent of them. He concludes: "...early and more general use of a combination tablet of this type which is effective at several grades of hypertension ... may well serve to prevent the later, more serious renal, cardiac, and cerebral complications often seen in untreated hypertensives."

References: 1. Hobbs, L. F.: Virginia Med. Monthly 90:28 (Jan.) 1963. 2. Dupler, D. A., Greenwood, R. J., and Connell, J. T.: J.A.M.A. 174:123 (Sept. 10) 1960. 3. Reubi, F. C.: Proc. Soc. Exp. Biol. Med. 73:102 (Jan.) 1950. 4. Kleh, J., and Fazekas, J. F.: Amer. J. Med. Sci. 227:57 (Jan.) 1954.

Indications: Moderate to severe hypertension.

Caution: Give cautiously to patients with coronary artery disease, advanced renal damage, cerebral vascular accidents.

Average dosage: 1 or 2 tablets t.i.d.

Side effects & precautionary measures: SERPASIL® (reserpine CIBA): Severe mental depression has appeared in a small percentage of patients, primarily in a dose above 1 mg. daily (higher than that contained in maximal daily dosage of Ser-Ap-Es). When the drug is discontinued, depression usually disappears, but hospitalization and shock therapy are sometimes required. Daily dosage above 0.25 mg. is contraindicated in patients with a history of mental depression or peptic ulcer.

Withdraw reserpine 2 weeks before surgery, if possible. For emergency surgical procedures, give vagal blocking agents parenterally to prevent or reverse hypotension and/or bradycardia. Rare reactions: anorexia, headache, bizarre dreams, dizziness. Occasional side effects: lassitude, drowsiness, nasal congestion, looseness of stools, increased frequency of defecation.

APRESOLINE® hydrochloride (hydralazine hydrochloride CIBA): Occasional side effects: headache, dizziness, faintness, palpitation, skin rash, and drug fever. Rare side effects: Postural hypotension; circulatory collapse; an arthritis-like syndrome which may rarely, with continued administration, lead to a clinical picture simulating acute systemic lupus erythematosus. ESIDRIX® (hydrochlorothiazide CIBA): Watch for signs of fluid or electrolyte imbalance. Further electrolyte depletion may cause hypochloremic alkalosis and hypokalemia. Since the latter may precipitate digitalis intoxication, watch carefully patients who are also taking digitalis or its glycosides.

Pay special attention to electrolyte balance of patients with severe renal or hepatic insufficiency. In patients with cirrhosis and ascites, watch for symptoms of impending hepatic coma. Contraindicated in patients with oliguria and complete renal shutdown.

Rare reactions: purpura with or without thrombocytopenia, skin rash, photosensitivity, urticaria. Thiazides may decrease glucose tolerance; use cautiously in diabetics. Hyperuricemia may occur but is readily reversed by a uricosuric agent.

Occasional side effects: nitrogen retention (in hypertensive patients), nausea, anorexia, headache, restlessness, constipation.

Supplied: Tablets (salmon pink), each containing 0.1 mg. reserpine, 25 mg. hydralazine hydrochloride, and 15 mg. hydrochlorothiazide.

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Ser-Ap-Es®

reserpine 0.1 mg.
hydralazine
hydrochloride 25 mg.
hydrochlorothiazide 15 mg.

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STARTING TOMORROW MORNING 

this capsule can help one of your overweight patients do without her favorite (fattening) foods at meals—and during all the hours in between.

Dexamyl® Spansule®

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Each No. 2 capsule contains 15 mg. of Dexedrine® (brand of dextro amphetamine sulfate) and 1½ gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each No. 1 capsule contains 10 mg. of Dexedrine (brand of dextro amphetamine sulfate) and 1 gr. of amobarbital [Warning, may be habit forming].

The active ingredients of the 'Spansule' capsule are so prepared that a therapeutic dose is released promptly and the remaining medication, released gradually and without interruption, sustains the effect for 10 to 12 hours.

INDICATIONS: (1) For control of appetite in overweight; (2) for mood elevation in depressive states.

USUAL DOSAGE: One 'Dexamyl' *Spansule* capsule taken in the morning.

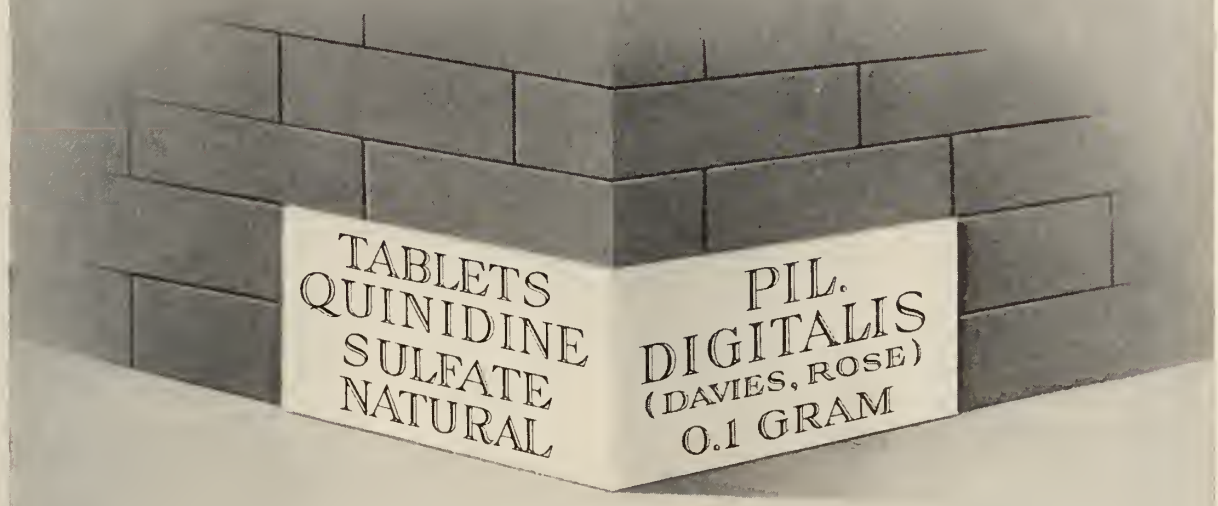
SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

CAUTIONS: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these rare instances withdrawal of medication is recommended. It is generally recognized that in pregnant patients all medications should be used cautiously, especially in the first trimester.

SUPPLIED: Bottles of 50 capsules.

Smith Kline & French Laboratories SK&F *Prescribing information Jan. 1963*

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The Dictionary defines a cornerstone as something of fundamental importance, just as Pil. Digitalis, (Davies, Rose) and Tablets Quinidine Sulfate Natural (Davies, Rose) are of fundamental importance in treating your cardiac patients. These preparations represent 60 years of experience and dependability in the manufacture of pharmaceuticals.

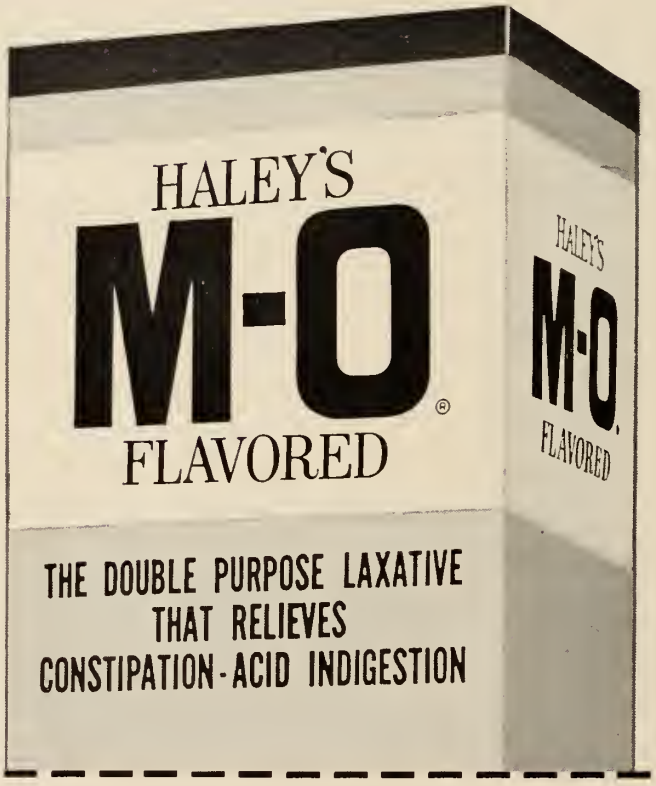
Pil. Digitalis (Davies, Rose), 0.1 Gram (approx. 1½ grains) which comprise the entire properties of the leaf, provide a dependable and effective means of digitalizing the cardiac patient, and of maintaining the necessary saturation.

Tablets Quinidine Sulfate Natural, 0.2 Gram (approx. 3 grains) are alkaloidally assayed and standardized, insuring uniformity and therapeutic dependability. Each tablet is scored for the convenient administration of half dosages.

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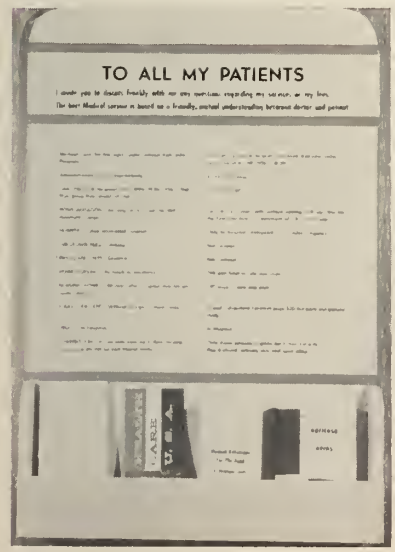
Division of Sterling Drug Inc., 1450 Broadway, New York 18, N. Y.

Say you saw it in the Journal of the Michigan State Medical Society

Muskegon Bulletin Boards Help Tell Medicine Story

Muskegon County Medical Society members are effectively reaching their patients by using new, handsome bulletin boards.

Leaders in the project have been John N. McNair, M.D., Chairman of the County Society Legislative Committee, and F. James Stubbart, M.D., secretary for the Committee. The Legislative Committee researched the idea to determine the cost, distribution of materials and other aspects, and worked closely with the Public Relations Committee (H. Clay Tellman, M.D., Chairman) in exploring both the legislative and public relations possibilities. The project then was presented to and approved by the County Society's governing board. The County Society offered to purchase the bulletin boards and to pay the installation costs in the doctor's office. A total of 49 boards have been erected in offices, used by 72 members of the Society, or about 70 per cent of the total county membership. Installation was not possible in some of the offices for various reasons.



The sturdy plywood board is 36 inches high and 24 inches wide and uses plastic-T-molding to make it easy to change the printed posters.

"It was decided," explains Edwin W. Prentice, M.D., president, "that the first printed message should call the attention of the patients to the coverage now given to the aged under the Kerr-Mills Law and to point out the limitations in the King-Anderson scheme."

The Public Relations Committee has responsibility for changing the posters and for distribution of the materials for the rack, which is part of the bulletin board.

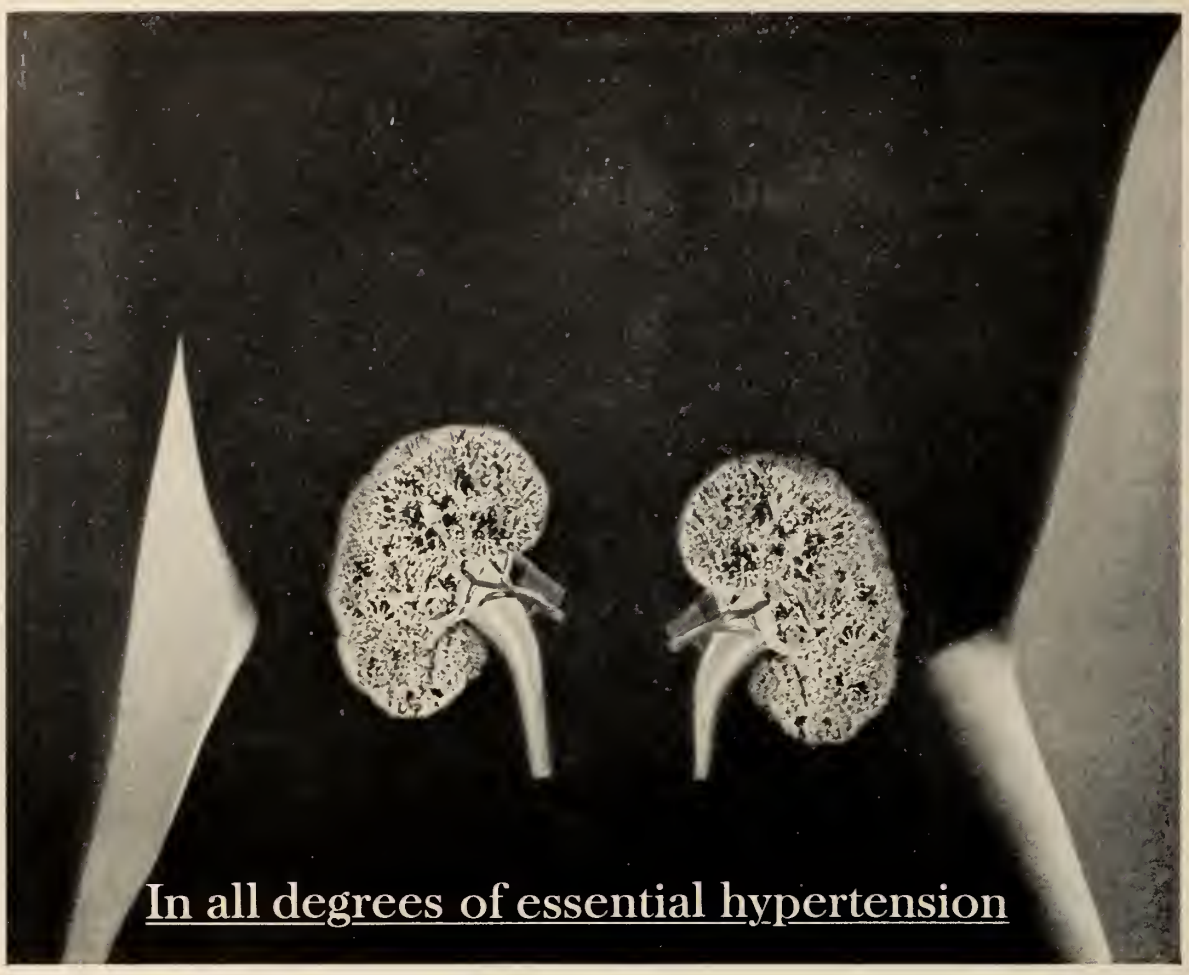
Interested county medical societies may write to Doctor Prentice for a diagram of the board and further information about this excellent legislative-public relations project.

* * *

Ionia-Montcalm Recruits Students

The Ionia-Montcalm County Medical Society reached a sizable number of high school students with a "Medicine As a Career" evening program. President Alfreds A. Birzgalis, M.D., reports that the AMA film, "I Am a Doctor" was shown, and that Richard J. O'Maley, M.D., Ionia, gave a short speech. Time was provided for questions and recruitment materials from AMA and MSMS were distributed.





Help protect the kidneys and other threatened organs

When treatment of hypertension is effective the danger of damage to the renal system is reduced.[1,2] "Hypertensive patients suffer from vascular deterioration roughly proportional to the severity of the hypertension... Reduction of blood pressure to normotensive levels reduces or arrests the progress of vascular damage with a resultant decrease in morbidity and mortality."[1] *Because Rautrax-N lowers blood pressure so effectively, it will help provide this important protection not only for the kidneys but also for the heart and brain of your hypertensive patients.* Rautrax-N is effective in mild,[3] moderate,[3,4] or severe hypertension.[4,5]

Dosage: Initially, 1 to 4 tablets daily preferably at mealtime. For maintenance, 1 or 2 tablets daily.

Side effects and precautions: Rauwolfia preparations may cause reversible extrapyramidal symptoms and emotional depression. Caution indicated in use with depression, suicidal tendencies, peptic ulcer. Minor side effects: diarrhea, weight gain, nausea, drowsiness. Bendroflumethiazide may cause reversible hyperuricemia and/or gout, unmask latent diabetes, increase glycosuria in diabetics. Caution indicated in use for patients on digitalis, with severely damaged kidneys, renal insufficiency, increasing azotemia, cirrhosis. Contraindicated in complete renal shutdown. Minor side effects: leg or abdominal cramps, pruritis, paresthesias, mild rashes.

Supply: Rautrax-N—capsule-shaped tablets providing 50 mg. Raudixin® [Rauwolfia serpentina whole root], 4 mg. Naturetin® [bendroflumethiazide], and 400 mg. potassium chloride. *Rautrax-N Modified*—50 mg. Raudixin [Rauwolfia serpentina whole root], 2 mg. Naturetin [bendroflumethiazide], and 400 mg. potassium chloride, in capsule-shaped tablets. For full information, see your Squibb Product Reference or Product Brief.

References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

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Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.

Usual dosage: 1 or 2 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50.

the original meprobamate

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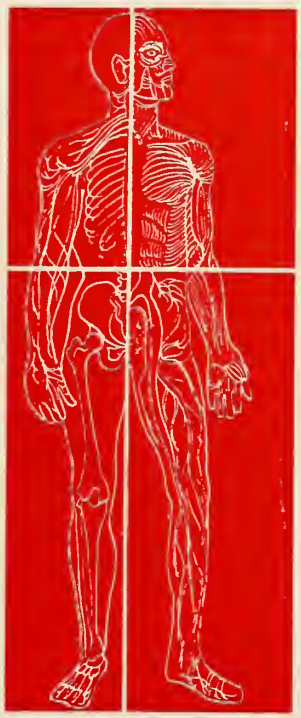
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Medical Needs of Rural Communities

Lee E. Feldkamp, M.D.
Plymouth, Michigan



REVIEW of the medical needs of communities outside of our metropolitan centers indicates a growing gap between the supply of new physicians trained in medical schools and the needs of the so-called rural communities.

The recent bulletins of the Michigan Health Council M.D. Placement Service list more than 100 requests for physicians, mostly from smaller communities. In fact, in times past many of these same communities have had resident medical care to the advantage of the community and the physician.

Much of this problem has evolved from the changing patterns of education within the medical profession. Ever increasing numbers of residencies available in specialties, mostly centered in metropolitan areas, have attracted a larger and larger percentage of the graduating medical students, with a declining number finding their way into general practice. After specialty training these men hesitate to go into smaller communities where they feel there might be insufficient work in their field to keep them busy and sustain their incomes without embarking upon practice in fields for which they have not prepared.

General practitioners are needed to fulfill the demands of the public for a recognized and readily available source for the medical care of families in rural communities. For this they desire a physician who is well educated, who is well trained and who is highly competent to provide the routine and basic medical care for all members of the family, children and adults alike, and when the need arises, advise and secure the services of qualified consultants. Group practice by specialists is usually not economically feasible in the individual rural communities. Certain specialties are definitely needed where area hospitals exist, particularly in pathology, anesthesiology and surgery.

Our challenge is to motivate physicians to provide for every area the best scientific medical care. To do this we need more young family physicians well trained in diagnostic skills in medicine, pediatrics, emergency care, gynecology and obstetrics who can provide rural communities with basic medical care. At least two years of intensive well-planned hospital training is recognized as needed preparation and such programs have been evolved by several university centers. Such programs are discussed in the JAMA for June 17, 1961, Volume 17, Number 11.

As physicians we know the responsibility of alerting the future

physicians of these needs. Presently many more men trained in specialties than can be economically absorbed are remaining in our metropolitan centers. The young surgeon or internist entering the field faces an ever growing group of colleagues without a corresponding increase in patient needs or available bedspace in hospitals. If he goes to the small community he finds less need for his services than he finds economically feasible. In either case he is forced to consider a practice outside his specialty. Thus, it would seem wise that more men should secure the broadly based training for family practice, enabling them to become physicians skilled in providing the basic needs of the public for good medical care, particularly in the smaller communities where they are so badly needed.

Entering family practice with diligence and proper background, the young physician will find excellent opportunities for professional success in the rural community. He will find it a pleasant place in which to live and raise his family, close to those who place their trust and confidence in him. Recreational opportunities are often abundant and readily accessible. He can do a most satisfying practice in his office and as much hospital practice as his background and training will qualify. Transportation and educational programs enable him to remain as abreast of medical progress as most of his city colleagues and diligent use of these opportunities will constantly add to his fund of knowledge and stature in medicine.

Isolation of the physician from his colleagues in the small community is no longer necessary with modern transportation. He can work with his consultants both easily and quickly. With men properly trained and so located that they may provide prompt and easily accessible care we can make even greater inroads against morbidity and mortality and thus derive the benefits of modern medicine for those in small communities as well as large.

Medicine's laudable zeal in extending the scientific capabilities and general quality of medical care is most praiseworthy, but at the same time we must not allow it to interfere with the application of sound basic medical care to all people wherever they may live.

It is as important to provide the proper care for the small child ill with scarlet fever or measles, and the puncture wound of the foot which the farmer suffers, as it is to treat the atherosclerotic aorta by means of an aortic graft. The "slight sore throat" unattended today may be the scarred mitral valve of tomorrow. With human nature as it is, the tendency of the patient is to delay if care is not readily available.

The need for good preventive medicine—pediatrics, obstetrical care, dermatology and all other phases of medical care—is as important to the individual in a small community as in a large city.

Hospital Alcoholism Units

Treatment for alcoholism and alcoholic psychosis should, as far as possible, be given in specialized units in psychiatric hospitals or in psychiatric sections of general hospitals, the Ministry of Health of England and Wales has recommended in a memorandum to hospital authorities.

Hospital boards which have not established such units should do so, the memorandum suggested. The initial aim is to have one such unit per region.

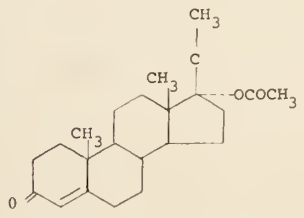
The recommendations are the outcome of a recent review of hospital provision for treatment of alcoholism by the Standing Medical and Standing Mental Health Advisory Committees. Their recommendations were endorsed by the Central Health Services Council.

The hospital units will normally be headed by psychiatrists or operated in association with them. It is suggested that the units have 8 to 16 beds, a number convenient for group therapy, which the advisory committees regard as a valuable form of treatment. It will be necessary, the memorandum states, for the special units to conduct outpatient clinics and to cooperate in aftercare with Alcoholics Anonymous and, where appropriate, with the local health authority and other interested agencies.—Excerpted from *Public Health Notes*, The Journal of the Royal Institute of Public Health and Hygiene, p. 180, August, 1962.

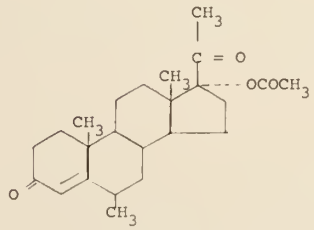
Hormonal Management of the Female Reproductive Tract

F. P. Rhoades, M.D.
Detroit, Michigan

THE HUMAN female reproductive tract is subject to endocrine irregularities. The modern management of these irregularities began with the isolation and clinical application of the ovarian hormones, estrogen and progesterone. A recently synthesized derivative of progesterone, medroxyprogesterone acetate, has found wide acceptance in the management of the endocrine irregularities of the female reproductive tract. It is the purpose of this paper to review the clinical applications of medroxyprogesterone acetate.



17-Alpha-hydroxyprogesterone acetate



6-methyl-17-alpha-hydroxyprogesterone acetate

Fig. 1.

Chemical and Experimental Data

Medroxyprogesterone acetate is synthesized by methylating 17-alpha-hydroxyprogesterone at the sixth position. This modification has resulted in a 10 to 20 fold increase in progestational potency.

This preparation, administered orally or subcutaneously to rabbits, has a greater progestational potency than other preparations.[1,2,3] In ovariectomized rats, medroxyprogesterone acetate shows unusual potency in production of a secretory endometrium and in maintenance of pregnancy.[4]

TABLE I. PROGESTATIONAL ACTIVITIES OF SEVERAL PROGESTINS

Compound	Route of Administration				Estrone Antagonism Assay
	Subcutaneous		Oral		
	Enzyme Test	G/M Test	Enzyme Test	G/M Test	
Progesterone	1.0	1.0	X	X	1
17-ethinyl-19-nortestosterone	0.1	0.2	1.0	0.5	X
17-ethinyl-5(10)-estraenolone	X	X	0.3	0.5	X
17-hydroxyprogesterone acetate	7.3	3.3	1.0	1.0	1.2
Medroxyprogesterone acetate	44.1	33.8	13.6	13.0	2.9

Adapted from: Elton, Edgren, Calhoun[2] and Miyake and Pincus[5].

Animal studies indicate that the androgenic potential of medroxyprogesterone acetate is less than other progestational steroids. On a weight basis, it is 1/8 as potent a seminal vesicle stimulator as ethisterone by the oral route, but it is hundreds of times as potent as a progestin.[5]

The ability of medroxyprogesterone acetate to virilize the female rat fetus has been demonstrated only at doses far in excess of its effective progestogenic range. Further evidence of its low androgenic potential is that not one confirmed instance of human female fetal masculinization following its use in abortion has been reported.[6,7,8]

The progestational activity of medroxyprogesterone acetate in women was determined by its ability to delay menses and by its effect upon the endometrium, the cervical mucus, and basal body temperature. It was found to be more than 300 times as efficacious as progestrone in delaying menses for 14 days.[9] In daily oral doses of 10 to 15 mg. it consistently induced

TABLE II. PREGNANCY MAINTENANCE WITH VARIOUS PROGESTINS IN RATS OVARIECTOMIZED ON THE EIGHTH DAY OF PREGNANCY

Compound	Dosage mg.	Successful Pregnancies
Progesterone	8	5/5
	4	4/5
	2	1/5
17α-hydroxyprogesterone acetate	100	0/5
17α-ethyl-19-nortestosterone	10	4/4
	5	3/3
	1	1/4
	0.1	0/1
Medroxyprogesterone acetate	40	3/3
	20	3/3
	10	7/7
	5	4/4
	2.5	5/5
	1.25	4/5
	.625	4/4
	.313	3/3
	.150	5/5
	.075	3/5
	.040	0/3

Adapted from J. C. Stucki[4].

secretory changes of the endometrium and partly or completely inhibited cervical ferning.[10-12]

Clinical Data

Premenstrual Tension Syndrome and Dysmenorrhea.—The premenstrual tension syndrome, which the majority of women encounter at some time during the reproductive years, occurs five to ten days before menstruation. This symptom complex of emotional and physiologic disturbances is responsible for considerable personal distress as well as social and economic repercussions. During the latter half of the menstrual cycle the patient experiences a varied combination of irritability, depression, anxiety, crying spells, headaches, nausea, edema, bloating, mastalgia, insomnia, weight gain, acne, and aphthous ulcers.

This syndrome, complex in symptomatology, is obscure in etiology. The numerous theories advanced of its etiology have led to as many therapeutic regimens. In practice, no one therapeutic measure will be effective in all patients. "Only one fact emerges clearly from this brief review of theories and therapeutics: premenstrual tension is a complex syndrome in which several mechanisms play a part. Partial relief can be achieved by correcting any one of these mechanisms, but the aim of treatment should be to alleviate the entire symptom complex. At the present time, this probably can be achieved only by employing a combination of agents."[13]

Medroxyprogesterone acetate combined with ectylurea, a tranquilizer, and ethoxzolamide, a diuretic, is highly effective, in relieving the symptoms of the premenstrual tension syndrome.

In one study[14] of 263 patients, satisfactory relief of the symptoms of the premenstrual tenison syndrome was obtained in 230 patients receiving medroxyprogesterone-ectylurea-ethoxzolamide. Meyer[15] reported that this combination prevented all premenstrual discomfort in 63 of 88 patients and prevented most distress in 14 patients. Medroxyprogesterone acetate alone relieved all symptoms in 40 per cent of patients in one group while the combination provided satisfactory relief in 80 per cent in another group.[16] In 30 patients receiving this combination, Warfield[17] reported 29 experienced satisfactory symptomatic relief.

TABLE III. ANDROGENIC ACTIVITY OF SOME PROGESTATIONAL STEROIDS IN THE RAT

	Oral Adm.		Subcutaneous	
	Seminal Vesicle	Prostate	Seminal Vesicle	Prostate
Ethisterone	3	1	1	1
Norethindrone	2	2	2	v. sl.
Progesterone	v. sl.	3	—	—
Norethynodrel+17α-ethinyl-estradiol, 3-methyl ether (Enovid)	1	4	3	v. sl.
Hydroxyprogesterone acetate (Prodox)	none	5	—	—
Medroxyprogesterone acetate (Provera)	v. sl.	6	v. sl.	v. sl.
17α-(2-Methallyl)-19-nortestosterone (SC-9022)	—	—	none	v. sl.

Painful cramps occur at the time of menstruation in some women without ovarian or uterine pathology. This condition, termed essential dysmenorrhea, is often of such severity that the patient is forced to bed for several days. Barfield et al[14] reported that 92 of 124 patients with dysmenorrhea were improved or completely relieved following one tablet of medroxyprogesterone-ectylurea-ethoxzolamide twice daily for ten days prior to expected onset of menses.

Amenorrhea-Pregnancy Test.—The occurrence of amennorrhea in a previously normally menstruating patient may signal either functional or organic disturbances in the ovary, the anterior pituitary gland, the central nervous system, and the general body tissues or a pregnancy. When amenorrhea occurs without demonstrable organic disease, it may be assumed that the ovarian dysfunction is ameliorable. This is particularly important in cases of infertility accompanied

by anovulatory amenorrhea where rebound stimulation may result in pregnancy.

Some patients produce sufficient endogenous estrogen to maintain an adequate proliferative endometrium and will experience withdrawal bleeding following a lating, the follicles continue to produce estrogen. The result is marked hyperplasia and a "Swiss-Cheese" type of endometrium which ultimately breaks down and bleeds. During the period of endometrial proliferation, the patient may be amenorrheic. The clinical

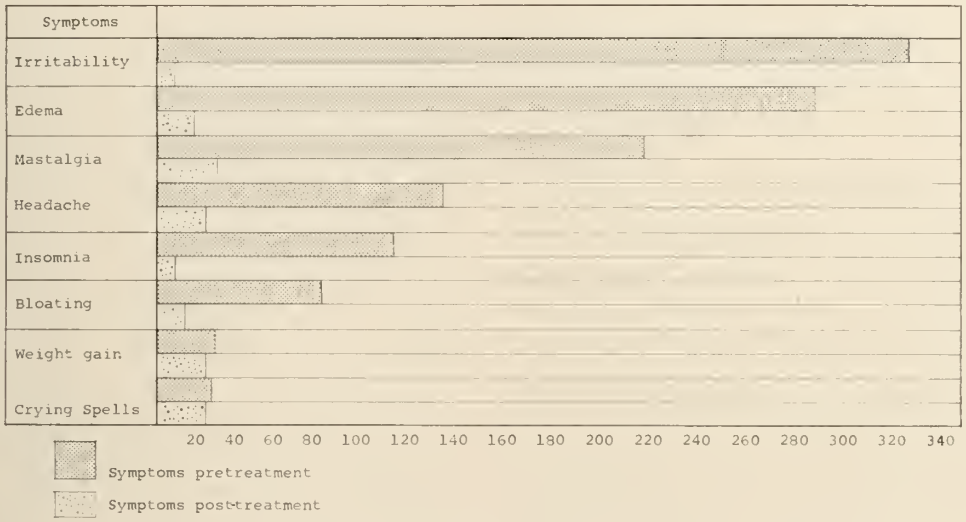


Fig. 2. Relief of premenstrual symptoms with medroxyprogesterone-ectylurea-ethoxzolimide.

course of progesterone therapy. Others are deficient in estrogen and will require estrogen priming to induce progesterone withdrawal bleeding. Hamblen et al.[18] and Greenblatt and Barfield[12] reported that cyclic medroxyprogesterone therapy in doses of 1 to 30 mg. daily induced withdrawal bleeding. Two failures were reported by Greenblatt and Barfield; one due to pregnancy and the other due to inadequate dosage, 1.0 mg. daily.

Amenorrhea may be due to an unexpected pregnancy. Since the gonadotropic hormone levels during early pregnancy are inadequate for biological pregnancy tests, a rapid, reliable, and safe oral pregnancy test is desirable. Medroxyprogesterone, given in doses of 2.5 to 100 mg. for four or five days, will induce withdrawal bleeding in the non-pregnant patient 98.5 per cent of the time.[19] The usual recommended dose is 10 mg. daily for five days and in the non-pregnant patient with adequate endogenous estrogen withdrawal bleeding will usually occur within two to seven days. Normal menstruation was successfully reestablished in 73 per cent of the non-pregnant patients in this study by means of this short term one cycle therapy.

Functional Uterine Bleeding (Metropathia Hemorrhagica).—Functional uterine bleeding is an indication of ovulatory failure. Although the ovaries stop ovumanifestations usually alternate between amenorrhea and irregular profuse or scanty bleeding. Barfield and Greenblatt[20] and Hamblen et al.[18] reported regression of hyperplastic endometria and control of symptoms following the use of medroxyprogesterone acetate.

The therapeutic approach is determined by the symptoms when the patient is seen. If the patient is amenorrheic, she should be treated according to the plan outlined in the section under Amenorrhea-Pregnancy Test. If the patient is actively bleeding, one or two injections of 100 mg. of medroxyprogesterone acetate will usually control the bleeding. Weekly injections for several months will result in atrophic changes in the endometrium which may result in improvement.[20]

Infertility.—It has been estimated that ten per cent of couples in the United States are involuntarily childless and that one third of these are due to deficiencies in the female. When luteal phase deficiency is the major factor in infertility it can often be corrected with progestational therapy. Luteal phase deficiency may be present in the normally menstruating patient with an inadequate secretory endometrium as well as in the amenorrheic patient.

A group of 32 infertile patients with proven luteal phase deficiency were divided by Finkler[21] into four categories: one or two abortions, habitual abortions,

threatened abortions, and functional sterility. These patients were given 10 mg. of medroxyprogesterone acetate once a day for ten days beginning on the 15th or 16th day of the cycle for three or four cycles. Improvement of luteal phase deficiency was checked by basal body temperature charts, vaginal smears, and when possible endometrial biopsies. When conception occurred therapy was continued during the first trimester of pregnancy. In this study, the luteal phase deficiency was improved in 23 of the patients and there were 17 pregnancies, 14 of which went to term.

Endometriosis.—Endometriosis is accompanied by infertility, dysmenorrhea, menstrual irregularities, and pressure on the structures adjacent to the aberrant tissue. When a patient with endometriosis becomes pregnant there is marked relief of symptoms and regression of aberrant tissue. In recent years the medical management of endometriosis with hormones has made surgical intervention largely unnecessary.

The induction and maintenance of pseudopregnancy with medroxyprogesterone acetate provides relief of many of the symptoms of endometriosis.[22] Medroxyprogesterone acetate intramuscular injections with supplementary estrogen will induce and maintain decidua in women.[23] Kistner[24] reported that in follow-up studies in 110 patients, 42 per cent of the patients who were infertile because of endometriosis became pregnant, 87 per cent experienced remission, and 8 per cent had a recurrence of endometriosis following medroxyprogesterone acetate therapy. The dosage schedule was 2 cc. (100 mg.) intramuscularly every two weeks for four doses, then 2 cc. every four weeks; oral estrogen was added to prevent breakthrough bleeding. Therapy was continued for three to 12 months, depending upon the extent of the disease.

Spontaneous ovulation and menstruation has been delayed in a few patients following prolonged intramuscular medroxyprogesterone acetate therapy. The etiology of this delay is under investigation.

Threatened and Habitual Abortion.—Abortion, the loss of the products of conception before term, may be due to mechanical difficulties, congenital abnormalities, or hormoral deficiencies. Whether the hormonal deficiencies are due to a defective trophoblast, corpus luteum, or placenta, the gravity of the threat makes prompt supportive therapy with adjunctive progesterone the therapy of choice.

The selection of the correct progestin is important because of possible female fetal masculinization. Recent reports[25-30] indicate that a number of progestins have virilized female fetuses when administered to patients threatening to abort. Not one confirmed case of female fetal masculinization has been reported following the use of medroxyprogesterone acetate for abortion,[31] although in high doses it has virilized the female rat fetus.[6-8,32]

Medroxyprogesterone acetate has been used extensively for threatened abortion with salvage rates of 71 to 80 per cent.[33-34] The usual oral dosage of medroxyprogesterone acetate employed was either 10 mg. daily from six weeks to term or 20 mg. daily from six to 18 weeks. When signs of abortion continued or reoccurred, the daily dosage was increased.[34] Patients with indications of imminent abortion were given intramuscular injections of medroxyprogesterone acetate, in doses of 50 to 100 mg. one to three times in 24 hours. When symptoms subsided the dosage was gradually decreased to 10 mg. orally per day.[33]

Contraception.—Whether contraception with oral progestins is mediated by direct action on the ovary, pituitary, or nidation has not been fully determined.[35-36] Breakthrough bleeding or premature menstruation occurs when these agents are used without estrogen.[12]

Medroxyprogesterone acetate, 10 mg., plus ethinyl estradiol 0.05 mg., was reported by Gold, et al.[37] to be 100 per cent effective as an oral contraceptive when administered to 61 patients for 272 cycles. An incidence of 29 per cent of intermenstrual spotting or bleeding was reported mainly in the first three cycles of therapy. The usual dosage used was one tablet of medroxyprogesterone acetate-ethinyl estradiol daily from the fifth through the twenty-fifth day of the menstrual cycle. Withdrawal bleeding occurred three to five days after therapy was stopped.

Hypoplastic Uterus.—Migliavacci[38] reported that the administration of medroxyprogesterone acetate and ethinyl estradiol for four weeks to patients with hypoplastic uteruses, as demonstrated by hysterograms, will produce uterine enlargement equal to a full-size normal uterus. A condition of pseudopregnancy was produced and was followed by actual pregnancy immediately or within a short time after therapy.

Constitutional Sexual Precocity.—Kupperman and Epstein[39] administered 150 to 200 mg. of medroxyprogesterone acetate intramuscularly every 10 to 14 days to five sexually precocious girls, four to 10 years of age. Menstrual bleeding disappeared, vaginal smears reverted to the castrate type, and there was a signifi-

cant decrease in breast size, Gonadal activity was completely suppressed in two sexually precocious boys, 11 and 12 years of age, as evidenced by the suppression of spermatogenesis and total neutral 17-ketosteroid excretion.

Summary

Medroxyprogesterone acetate has been used with satisfactory results in the relief of the premenstrual tension syndrome and dysmenorrhea, secondary amenorrhea and as a pregnancy test, infertility, endometriosis, functional uterine bleeding, threatened and habitual abortion, contraception, hypoplastic uterus, and constitutional sexual precocity. Minimal side effects and the lack of androgenic or estrogenic potential makes it the progestin of choice.

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Nutrition in Geriatrics

C. Howard Ross, M.D.
Jeannette Albert Ross, M.N.Sc.
Ann Arbor, Michigan

IT IS my intention to garner the best of food performance in my own practice and season it with reports and advice from observers, nutritionists and geriatric practitioners removed from Ann Arbor. In such a plan the hope is to present a paper that may be employed by the young physicians entering the field of Geriatrics, as somewhat authoritative in Food selectivities for the Elderly. We shall be dealing with all decades beyond 65, but wish to emphasize the years past 80, when one must be concerned with both undernutrition and over-nutrition.

The subject may appear to hold the aspects of a "double header," and indeed this is true. We must compromise with our dictates and our accomplishments. The ancient "tea and toast" complaints against grandma can be tucked into the worry-wart brain of the alarmist and yield in favor of "too little protein" and "not enough variety".

The main groups of recommended foods for our population include meats, fish, milk, cheese, eggs, cereals and other grain products, fruits, vegetables. One cannot throw this list at a recluse and clear his conscience forthwith. Rather comes the challenge to analyze the food program now in existence, compliment it rather highly, and then complement it shyly.

Surely, when a wise old couple has reached the age of bonus in experience, the two of them have not suddenly become entirely negative in food consideration. We must penetrate their state of passivity.

Building on Wisdom

An explorer in his nineties with clear blue eyes, rose-bloom in the cheeks and reasonable ferocity of appetite, once asked me to prepare for him a diet list applicable to his age and physical status.

I first requested that he outline the "food leanings" that he was then enjoying. The sheet ran something like the following:

Breakfast:

1—Soft poached egg on whole wheat toast.
2—One slice of crisp bacon. Occasionally he employed beef bacon. I can assure you that this is an excellent dish.
3—Four ounces of fruit juice which varied with the mood of the elderly sipper and the opportunity of the refrigerator.
4—Two heaping tablespoons of 40 per cent raisin bran served with whole milk.
5—A taste of marmalade.
6—Clear coffee or skim milk.

Lunch:

1—Four ounces of vegetable and beef soup was his choice. Variable broths and consommes entered into the picture, as the days sped by.
2—Two ounces of chopped salad with one ounce of cottage cheese or a cheese dressing.
3—Small broiled lean chop:—lamb, beef, veal or pork.
4—Small dish of fruit jello.
5—Clear tea or skim milk.
6—One slice of oatmeal bread and half a pat of butter.

Dinner:

1—If the afternoon did not afford sufficient exercise, this meal was reduced to less than supper level with a bowl of "coffee soup", made of equal parts of coffee to serve, plus milk and cubes of lightly buttered toast.
2—However, if work in the garden steamed up his vitals, he began with two ounces of buttered green vegetable.
3—Two ounces of mashed potato or rice.
4—Small hamburger or slice of meat loaf, or petite slab of liver.
5—Whole wheat toast, lightly buttered.
6—Cup of custard.
7—Tea or other innocent drink, such as buttermilk.

After the perusal of his food selections, and observing ample protein ration, I signed my name boldly at the bottom of the sheet, stating that 90 or more successful years, plus a proper and ample variety of portions made him the *expert* and me the *observer*. My only conscience-saver was an arbitrary addition of a multi-vitamin capsule daily.

Here, I believe is the place and opportunity to raise

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the warning flag to oldsters against the house-to-house peddler of the $20.00 bottle of "guaranteed" green leaf pills or related nostrums.

The Languid

When an elderly invalid is confined to bed and room, the situation thickens. Very soon, if at all possible, some physical performance plus occupational therapy must be instituted, in addition to self-care. Rides in the wheel chair, or car, with a few jerks of the hoe in the garden, even from a sitting position—will do much to "earn a meal" physically.

Proteins and Calories

Many partly active women in their eighties and nineties adjust to a weight level of 110 to 130 pounds and men lean towards 140 to 165 pounds. Height and body frame become proper considerations. The women average 60 grams of *protein* and the men can easily attain the figure of 70 grams. Those that are reclaimed to active life can climb the scale a bit higher. Varying with weight and constitutional type, 1000 to 1200 calories of total food a day will maintain life in bed; 1200 to 1800 calories may be counted upon to sustain life in bed and chair; 1800 to 2000 calories will permit walks into the hall or activity rooms; 2000 to 2200 calories should care for the part-time gardener or one dealing with the loom, light housework, palette, wood work or mild exploration into the woods. Beyond the last figure rests the realm of the full life.

Carbohydrates

Sweets that are in direct evidence are reduced to a minimum. There is always the drop of vanilla flavor available. It is wiser to obtain metabolized glucose from vegetables, fruits and grain products than from sugar and candies in open servings. However, any dessert that agrees is not tabooed, provided it is not the major portion of the meal and does not interfere with a restricted diet, as in the case of diabetes mellitus. From 125 to 175 grams of carbohydrates can be tolerated with a protein balance of 60 to 80 grams or more. In conservative diets, we must still face an average of 100 grams of fats for the oldsters to manage.

Fats

Until we know more regarding the mysteries of cholesterol and fat metabolism as related to atherosclerosis, I assume the duties of an arbitrary dictator, pronouncing rules as follows:

1—Trim off all visible fats from meats.
2—Make the bacon crisp but not charred and blot on paper toweling before serving.
3—Gravy helpings reduced to two teaspoons.
4—Fat-spread per meal not to exceed one pat.
5—Occasional ice cream not to exceed 2 ounces or ¼ of a cup.
6—Occasional pastry: half a serving (2-inch sector).
7—Fried foods are in the descendancy. One can always poach, boil, broil or bake—or fry with a minimum amount of unsaturated fat. A soft—slow fried egg—can be managed with as little as half a teaspoon of fat.
8—*Margarine.* Years ago this item was in poor social status, as it reflected upon the economic depletion of the hostess. Nowadays, the major brands are dependable, and the ingredients are within nutrition limits. There is the added awareness that economical unsaturated fats are in the offing. Again our state of knowledge is not superior. When in doubt, use "less" rather than "more" and keep the patient active and lean.
9—Salad dressings should be prepared from vegetable oils, cheese and fruit juices.
10—Whole milk is substituted for cream.

Vitamins and Minerals

You will note the arbitrary addition of a daily vitamin capsule to the nonagenerian's diet. This is of course debatable. I urge the consideration of color, variety and balance in food selection as a step in the right direction. The purpose of this paragraph is to pay tribute, but not to raise a controversy, where bill-boards and prescription pads meet. Suffice it to say—let us not forget the proper inclusion of fruits, vegetables, milk products and organ meats when food factors, iron and calcium are under scrutiny.

Water

Since water constitutes about two thirds of the total body weight and is the body's principal component from the anatomical as well as physical point of view, water between meals is a must. Watery substances in the body act as lubricants and water as a bulk in the intestinal tract aids elimination.

Constipation

A man who has reduced his occupation to sitting, rocking and mild stirrings, forgets to drink water. The lower bowel cries out in complaint, and sad moments are spent straining at stool.

One of my first demands is bodily exercise, beginning with self-care and advancing to regular walks or gardening endeavors. The next "must" requires a glass of water half an hour before breakfast. This pattern yields a livening up of peristaltic activity. Then, breakfast should not be "wolfed down" but eaten slowly and with relish.

My best retainer of water in the large bowel is obtained from a dried fruit recipe that my family doctor wrote out for me when I was a youth. It pro-

vides a supply for several breakfasts and does not necessarily require added sugar:

Half a pound of dried apricots.
Half a pound of dried figs.
Half a pound of dried prunes.
Half a pound of dried raisins.

Soak over night in 2 pints of water; bring to a boil in the morning, turn down the fire and simmer for 45 minutes. Do not boil the fruit bodies out of shape, as then the esthetic factor is ruined. Cool. Refrigerate.

Serve 2 ounces for breakfast and cover with a fruit juice that varies in identity from day to day.

As time passes, within 30 minutes following breakfast, a bowel movement can be expected. If none is obtained, a small retention enema should be employed. The pattern of the "breakfast bowel" soon can be depended upon, even though a neglectful life-time of constipation is quoted in the history. Also a glycerine suppository may be inserted before breakfast, with movement directly afterwards. The doctor must explain that constipation is either in the head or can be cured by applying the head. Laxatives can be flushed into the sewer directly from the bottle. Vitamin-A-saturated mineral oil may be used as a lubricant.

Bodily Care

The slovenly oldster has lost respect for himself and his neighbor. Pick-up, clean-up, press-up, bathe-up, shave-up campaigns are as necessary for the spirit as food is for the physiology. I have found that a *clean old man hates himself less* and may be approached by those interested with genuine rapport. The spots on the clothing and bathroom odors are not conducive to fellowship. This situation is contagious. The better the exterior, the better the interior welcomes a nutritious state. A spiritual climb comes from both sides.

Also the wisdom of a clean grandpa and his tales are better appreciated by the grand-children, crawling and prowling over him, climbing to even greater heights and clamoring for more, more, more.

Tobacco

Since I am convinced that tobacco is the modern cardiac and pulmonary scourge of mankind, it becomes difficult to remain silent on the subject. Hundreds of young men and a few women have never started to smoke due to my pseudo-scientific expostulations. Scores of middle-aged people have stopped the habit on my "biological dare".

The elderly smoker is a different breed. I say to him, "The purpose of a cigarette, if there is a purpose, is to waft one from the urgencies of hence to the pleasantries of thence, but three times a day after meals is enough wafting". Tobacco furnishes a sloppy, slouchy, slovenly, complaining approach to good nutritious meals.

Alcohol

An alcoholic drink should add to the niceties of existence and give life its 10 per cent kick in the "synapseal pants". I preach teetotalism for the confirmed alcoholic and conservatism to all. The geriatric level of drinking may include an occasional highball or cocktail and a glass of wine at dinner. However, to swish one's way through alcohol fails to perceive a means to an end. The results sadly find a miserable termination of life's processes. When reflections should bring great joy and nutrition should reach a glowing height, they both are squelched into the wavering background of uncertainity and oblivion. I have a hope that my vigorous oldsters, who have an awareness of the advantages and limitations of alcohol, may form a brigade to pick the Skid-Row unfortunates from the gutter and offer them the opportunities of rehabilitation.

Education

Unless a devasting stroke or like disaster has been experienced, there is no interdiction against education for the elderly. Rehabilitation of mind, body and nutrition—all are indulged in—these days. Group meetings, lectures, art creations, history discussions, activity centers—drama gatherings, and classes in foods—all are applicable. "A fellow told me," may not sound scientific, but if "the fellow" was a discussant in a class or group, his quote may be your lead to making a good point.

I have literally yanked scores of elderly recluses off their stale bottoms and activated them in neighborhood centers. The majority relished the change. Only a whimpering minority objected. The failures were my fault, of course, because I did not penetrate the organ-recital haze deeply enough or have the definitive persistency to gain results.

Whenever possible, I employ a member of an elderly discussion group as an "expert" in his field. A retired contractor nimbled up the fingers in petite wood carvings; an ancient blacksmith got the boys wild about metal shapings. An old has-been drama coach found new joy in discovering a Portia of 80 years, a Shylock of 90 and a Gratiano of 92. An ex-football coach and his stiff-kneed chef reduced their portions of the twenties and gave recipes for smothered steaks very tempting to the boys in their eighties.

One day, we took the whole team to the farmers'

market where they selected their goodies for a picnic, including youthful chickens, hand-roasted on a spit.

With enthusiasm, anything is possible, even the cheek-glow and the quickened corpuscles and the agility of stride.

A New Race of Specialists

After a pale and transparent silent specimen with a hemoglobin of 8 grams has been promoted to a talkative rehabilitant in nutrition and an active creature of 13 to 14 grams, he is recognized as having the rank of specialist. Where scientific data fail him, his example, though arbitrarily vocative, becomes extremely valuable. Where roaring feasts are planned toasts are given to the lad who made good.

Recipes are offered in exchange. New "chefs" are made in a fortnight. *Grandma is warned not to keep her nosey husband out of the kitchen.* Most men are somewhat crude when confined within four walls, but will bloom over a fire, inside or outside, with hungry guests waiting in salivary expectancy.

One of our best creators of food styling is a man in a wheel chair, who has a head on his shoulders and a most nervous pair of hands over a grill. He is the one who presented me with a furtive recipe for a "pep pill". It has been employed with happy relish:

1½ ounces slightly steamed spinach or other green vegetables placed over
2 ounces mildly broiled liver.
Hollow out the vegetable and drop in an egg sprinkled with Parmesan cheese.
Broil until the egg is jelled and serve piping hot at once.

It is good to the taste, nutritious to the body. The "pep-pillers" assembled eat of it eagerly and quote modifications, such as adding a rasher of bacon, a dash of paprika or a wee round of sausage. Our man takes notes for the future

Specific Diseases

In this paper, I have not attempted to outline the relationship between nutrition and diabetes mellitus, renal and hepatic problems, hypertension or cardiac disasters. Such fields are covered amply in the literature. Where enthusiasm must enter our philosophy, caution must also season the situation with proper laboratory and systemic findings.

My chief claim to existence is via the route of transforming neglect and a state of sadness into victory and a state of glow. Also—let me state—no one can plunge headlong into a realm of bliss without watching out for snags in the passing scenery. Sanitation and Nutrition do not jump at the snap of a finger.

Summary

An outline has been given regarding Geriatric Nutrition and food selections for the elderly.

One can build on wisdom obtained in advanced years.

A relationship has been given between calories and carbohydrates, fats and proteins.

Methods of avoiding constipation are promoted.

Bodily care is a must.

Education does not end in geriatrics.

A new race of elderly specialists in nutrition is discovered.

Specific diseases are presented eleswhere in the literature.

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715 N. University Avenue
Ann Arbor, Michigan

Pulmonary Contusion

Robert L. Tygart, M.D.
John A. Mitchell, M.D.
Wayne W. Glas, M.D.

Eloise, Michigan

PULMONARY contusion, while long recognized as a complication of chest injuries, has seldom been considered as a distinct lethal lesion. Many forms of treatment have been outlined for chest injuries with little recognition being given to the fact that it is the pulmonary contusion that is being treated.[1,2,6,8]

Pulmonary contusions fall into two categories depending on whether they have been produced by penetrating or non-penetrating injuries. It is readily apparent that a missile, pointed, or edged weapon is capable of doing severe damage to lung parenchyma. This aspect will not be discussed further. The remaining non-penetrating injuries can be divided into either blast or blunt trauma. The blast type is usually found under conditions involving explosions, or accidents with compressed gases and likewise will not be discussed here.

This paper deals with the problem of pulmonary contusion following blunt trauma.

Pathology

Microscopic examination of traumatized lung revealed several consistent features. These features could occur singly or in combination as can be seen in Figure 1. These findings were: (1) generalized or patchy edema as represented by dilated lymphatics and interstitial tissue, and fluid within the alveoli and the bronchiols, (2) congestion of vessels, (3) rupture of the alveoli with extravasation of blood into the air spaces, and (4) hematoma formation within the lung parenchyma.



Author

ROBERT L. TYGART, M.D.

Grossly, lungs showing only edema were large, pallid, patchily or confluently firm, pitted on pressure, and on cut section exuded considerable frothy fluid. Those contusions associated with gross parenchymal injury showed the above changes of edema plus any or all of the following: subpleural hemorrhage, intrapleural hematoma, parenchymal laceration, traumatic lung cavities, and hyperemia.

Radiology

Radiologically any one or all of the following may be present: (1) increased bronchovascular markings, (2) consolidation, (3) traumatic lung cavities, and (4) patchy and generalized hazing. Figure 2 is fairly representative of these findings.

These microscopic and radiologic changes were found within the first few hours, and were always present by 24 hours. Subsequent findings were, however, sometimes compounded by late associated complications.

In the past, causes of pulmonary contusions have been listed as: (1) compression of a semi-flexible thoracic wall with its associated elastic recoil, (2) transmission of the force to the underlying lung by the tissues of the thoracic wall, and (3) trauma to underlying lung by fractured rib ends.[10]

In addition to the physical violence involved, there are also physiologic changes which take place from the moment of injury that are quite important. The most important of these to be discussed here will be that of pulmonary edema following trauma. The physiology of edema production after injury to the lungs is not completely known.

Direct physical trauma to the lung stimulates the tracheobronchial mucosa with resultant increase in the glandular secretory activity (mucous). This resultant increased mucous production is then added to the physical damage already sustained by the lung parenchyma. This causes a vicious cycle.[5] The anoxia that

From the Department of Surgery, Wayne County General Hospital, Eloise, Michigan.

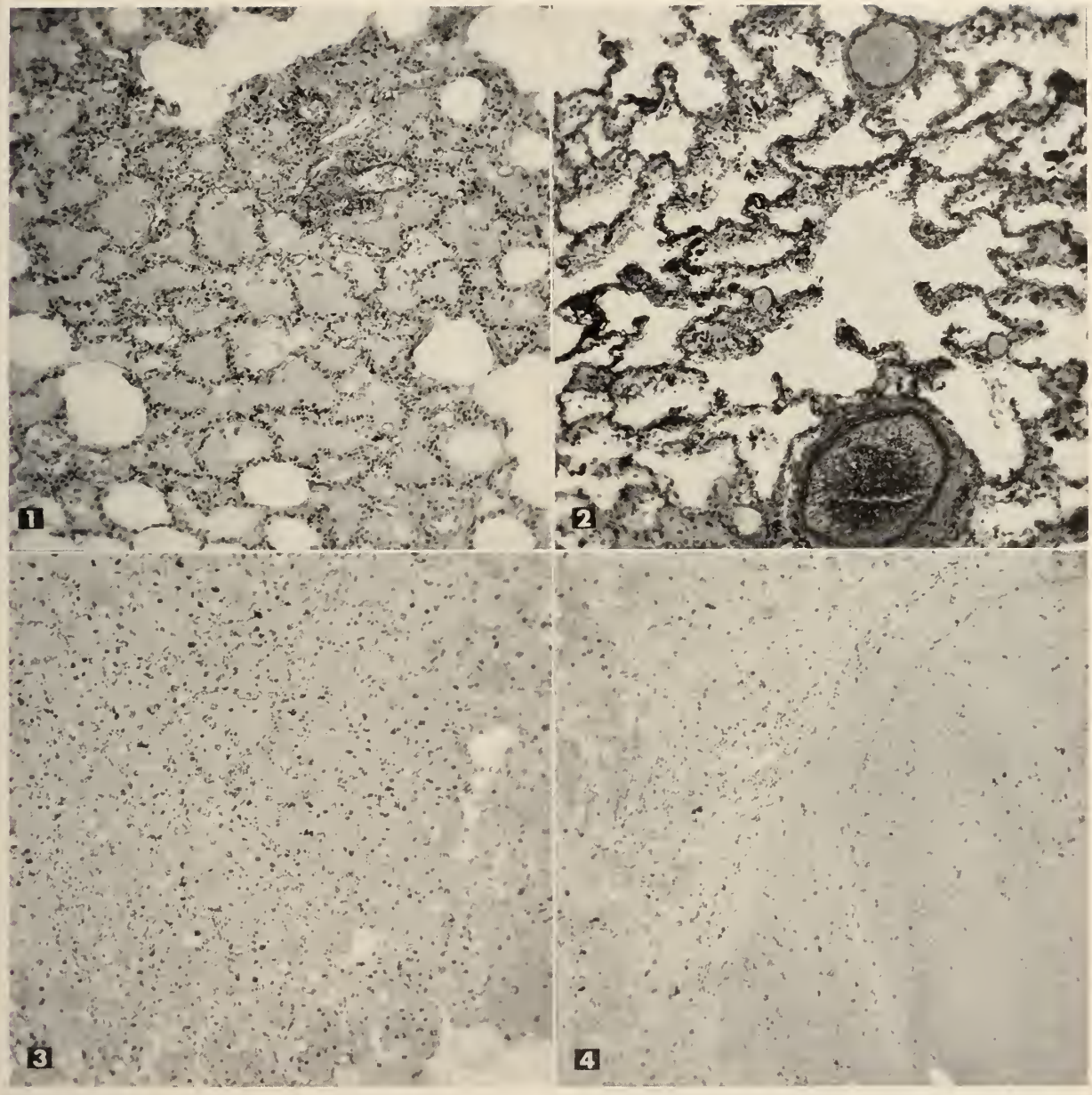


Fig. 1. Microscopic findings in pulmonary contusion. (1) Edema. (2) Congestion. (3) Extravasation of blood into alveoli. (4) Intrapulmonary hematoma.

develops produces a marked increase in capillary permeability with subsequent increased edema.[7]

Anoxia can also result from a pneumothorax, or, as a result of progressive atelectasis which may be secondary to shallow respirations and retained secretions. The latter is an important feature in the semi-comatose or unconscious patient and those who fail to cough due to pain of broken ribs.

Many of these people, when first seen, have been in shock for some time due to multiple injuries. Shock by itself in late stages is known to cause increased capillary permeability and contribute to pulmonary edema.

In association with these increased secretions, there is a reflex bronchoconstriction which tends to prevent clearing of them. This may partly explain the pulmonary transudate that accumulates in the face of increased expiratory resistance.[4]

Lung parenchyma which has not been directly injured, including the opposite lung, frequently contains considerable amounts of edema fluid. These are the patchy densities seen on x-ray. Daniel and Cate

conducted extensive experiments in dogs that indicated that the generalized wetness following local trauma is in part a reflex phenomenon.[3] They found that removal of a large portion of the sympathetic nerve supply to the lungs tended to prevent diffuse pulmonary edema.



Fig. 2. Typical x-ray findings of pulmonary contusion.

Material

In a three-and-one-half year period, 370 serious cases of chest trauma with rib fractures were seen and treated at our hospital. Of these patients, 117 had clinical and x-ray evidence of pulmonary contusion for an incidence of 31.6 per cent. An additional nine patients with pulmonary contusion without fractured ribs were not considered in this study. Complications in these 117 patients are listed by systems in Table I and are compared with those areas not showing contusion. The mortality can be seen in Table II.

It is generally accepted that these patients die of anoxia. Pulmonary ventilation is reduced to the point where the diminished vital capacity approaches that of tidal air. An oxygen debt and hypercarbia are produced secondary to this mechanical obstruction. With the oxygen debt, increased anoxia occurs when the oxygen supply and oxygen requirement becomes disproprotionate. This can happen in such simple exertions as talking, coughing or turning in bed. At this point, the oxygen demand exceeds the available capacity of the heart and lungs, and sudden death occurs.[6,9]

TABLE I. PULMONARY CONTUSION—COMPLICATIONS

	Fractured Ribs With P.C.	Without P.C.
Intrathoracic		
Hemothorax	39.3	32.9
Pneumothorax	44.6	35.9
Subcutaneous Emphysema	35.0	9.6
Paradox—Flail Chest	8.5	2.4
Cardiac Contusion	5.1	2.8
Intra-abdominal	11.1	12.6
Musculoskeletal	82.0	68.2
Neurological	15.4	8.9
Retroperitoneal	6.8	2.3

Seventeen of the patients with pulmonary contusion died as a direct result of their contusion. Three of the 17 deaths occurred within the first 24 hours with an average of six hours. The remaining 14 deaths occurred between one and 12 days with an average of four days.

TABLE II. MORTALITY

	With P.C.	Without P.C.
Pulmonary Contusion	13.7	
Cardiac	1.7	3.6
Lung (Embolism, Pneumonia)	1.7	2.9
Head Injury	6.0	0.0
Other	.8	2.4
Total	23.9	9.6

The clinical findings in this disease depend directly on the degree of injury. They vary from no outward findings with x-ray diagnosis only to the severely injured patient who presents himself in varying stages of consciousness exhibiting short, rapid respirations, tachycardia, cyanosis, splinting of the chest, copious endobronchial secretions, rhonchi and inspiratory and expiratory moist rales, and sometimes hemoptysis.

The critical time in the treatment of pulmonary contusions and their associated intrathoracic complications was the first 24 hours. Twenty-eight or about two-thirds of all hemothoraces were present within 24 hours. Forty-seven pneumothoraces and 34 instances of subcutaneous emphysema also occurred by this time. Twenty-four of 29 closed tube thoracostomies and 34 of 36 tracheostomies were done within the first 24 hours.

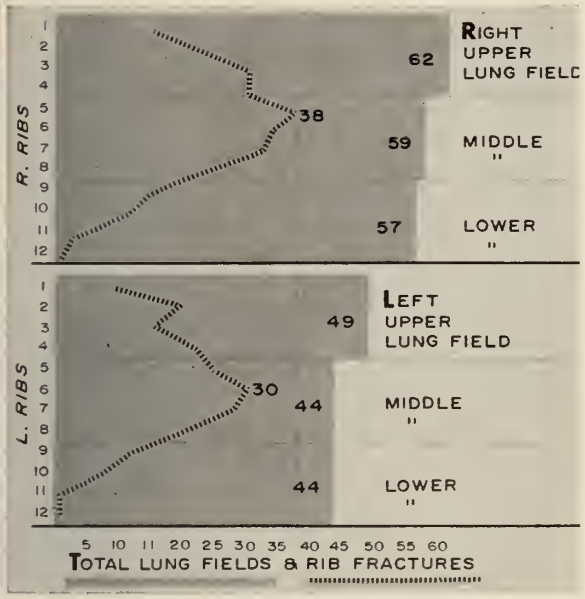


Fig. 3. Graph showing relationship between pulmonary contusion and associated rib fractures.

The number and location of fractured ribs and the extent and location of the pulmonary contusions have been plotted in Figure 3. As you can see, although most of the rib fractures occur in the middle one-third of the rib cage, there is a disproportionate number of contusions in the upper and lower lung fields. The site and extent of external injury and the site and extent of the pulmonary contusions are compared in Figure 4. In roughly one-third of the cases, there is no correlation between the two factors. It is impossible to predict how long it will take any given contusion to heal clinically or by x-ray. Recovery depends on the original type of contusion and the intrapulmonary complications associated with it. Pulmonary edema usually will clear within 48 hours. The remaining types clear, for the most part, within 20 days, but some have lasted up to 50 days depending on whether pneumonia, atelectasis, abscess formation, intrapulmonary hematoma or pulmonary fibrosis had developed. Evaluation and treatment of these patients is, therefore, an individual problem.

Recommended Treatment

Many patients will obviously not require all available measures. However, for thoroughness these measures are briefly as follows:

A. *Establishment of a Patent Airway* (particularly in the comatose patient)

B. *Management of Secretions*

1. Nasotracheal suction for retained secretions.
2. Judicious use of bronchoscopy for the patient who has difficulty raising secretions. This is necessary in those people in whom it is impossible to do nasotracheal suction and who do not appear to require tracheostomy.
3. Tracheostomy to clear copious recurring secretions, and cut down dead space and thereby reduce tidal air. This will also reduce endobronchial pressure so as to relieve the stimulus for formation of transudates and reduce the tendency for persistence and advancement of subcutaneous and mediastinal emphysema and pneumothorax.
4. Expectorants to help liquefy thickened secretions.
5. Use of detergent-type compounds by inhalation to help clear secretions.
6. Use of inhalation and parenteral enzymatic compounds to help clear secretions (Varidase, Dornovac, et cetera).
7. Use of bronchial dilators in conjunction with Nos. 5 and 6.

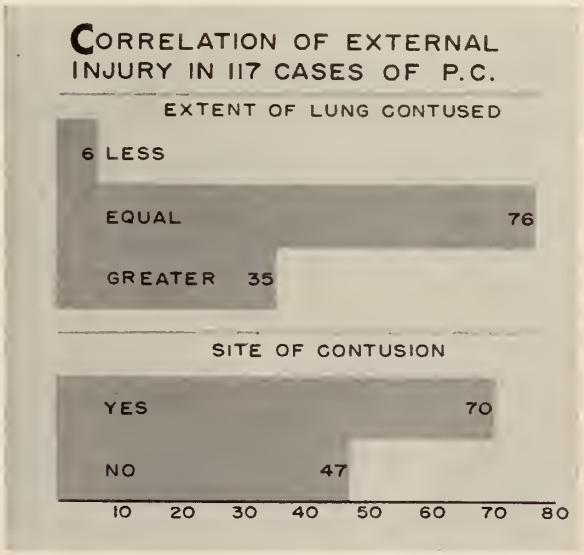


Fig. 4. Graph showing correlation between injury of the chest wall and pulmonary contusion.

C. *Intermittent Needle Thoracentesis or Tube Thoracotomy* (To control pneumothoraces and hemo-hydrothoraces)

D. *Management of Pain*

1. Intercostal blocks to relieve pain of broken ribs and to permit coughing.

2. Narcotics to relieve pain, preferably of the type producing maximal pain relief with minimal sedation.
3. Barbiturates to be avoided as they abolish the cough reflex and decrease respiration.

E. *Respiration*

1. Use of oxygen both by nasal catheter and positive pressure apparatus. This is especially important in suspected cardiac contusions.
2. Support of the flail paradoxical chest.
 (a) Circumferential strapping (condemned due to its restrictive action).
 (b) Sand bag support of injured area.
 (c) Traction appliances applied externally.
 (d) Internal pneumatic stabilization by such volume regulators as the Morch respirator.
3. Elevation of the head of the bed may make respiration easier.

F. *Thoracic Sympathetic Nerve Blocks* (as a possible means of interrupting the involved reflexes)

Summary and Conclusions

In summary, we have reviewed 117 cases of pulmonary contusion which were associated with fractured ribs. The site of broken ribs and external trauma were compared with the location and extent of pulmonary damage. The associated complications and mortality have been briefly mentioned.

Pulmonary contusions were present in 31.6 per cent of patients having chest trauma with associated fractured ribs. It was lethal in 13 per cent of these cases while an additional 10 per cent died of associated complications.

In only approximately two-thirds of these patients could pulmonary parenchymal damage be correlated with objective signs of external injury.

Our study indicates to us that the first 24 hours of treatment are, by far, the most important. In this period 4 per cent of all patients with contusions died. An additional 10 per cent died by the twelfth day. It is in this latter group that we believe there is some possibility of salvage. This will depend on our ability to improve oxygenation while reducing the effect of the veno-arterial shunt produced by the contusion.

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Medical Maxims

Persistent post-concussion headache beyond three months may indicate serious intracranial damage.

When narcotics are needed to relieve pain in arthritics search should be made for more profound disease.

Duodenal ulcer in the female may be accompanied by hyperparathyroidism.

In human leukemia more than one case in a family is extremely rare.

Gynecomastia may develop in some patients after prolonged digitalis therapy.

—From "711 Medical Maxims" by WILLIAM S. REVENO, M.D., Publisher, Charles C Thomas, Springfield, Illinois.

Nerve Deafness in Children

J. Lewis Dill, M.D.
Detroit, Michigan

OF ALL the handicaps that affect the human race, deafness appears to receive the least consideration. The impact of deafness in terms of educational, social, and occupational effects is not fully appreciated. The adult with normal hearing during early life feels acutely handicapped when a loss of hearing becomes apparent. How much greater is the handicap of a child deafened at birth or an early age? The child with loss of hearing at an early age must learn to hear and talk, receive an education, and prepare to enter into a world which shows little or no concern. The child with a loss of vision is truly pitied, but the child with impaired hearing is often "shunned", "kidded", or "scolded". What can or must be done to help this child grow up as a normal individual?

Exciting developments in otological surgery and otological research have aroused both the physician and the lay public, and stimulated an active interest in the many problems associated with deafness. The many patients who have improved hearing following otological surgery are enthusiastic in their praise. These excellent surgical results are still limited to certain types of deafness. At present, nerve deafness does not fall into this category, and the person who has a nerve deafness must seek the limited help available, since surgery and medical treatment fail to produce any improvement. We have much to offer the deafened child to help overcome his handicap, to utilize his other talents and the hearing still present, and to enable him to live a normal, useful life and take his rightful place in society. Prevention of deafness is still the preferred and best therapy.

Of the 93 children included in our group, 67 had a congenital nerve loss (72 per cent), and 26 had an acquired nerve loss (28 per cent); that is, approximately two and one-half times as many children had a congenital loss as had an acquired loss. Approximately 50 per cent of the children with congenital loss were seen before five years of age as opposed to 23 per cent with acquired loss. These figures suggest that deafened children under five years of age are more likely to have congenital nerve deafness. The parents noted the deafness in their child as follows: in the children with congenital loss, one child was under one year of age, 32 were between one and five years of age and six were over 10 years of age. In the children with acquired nerve deafness, six were under five years of age, nine were between five and 10 years of age, and 11 were over 10 years of age.

The cause of the hearing loss varied. Of the 26 children with an acquired loss, no cause was noted in seven. In eight, the loss was due to infectious disease (measles, mumps, influenza) and in three to meningitis. In two, the hearing loss was associated with otitis media and in two it was due to streptomycin therapy. One child had epilepsy and brain damage and one had a skull fracture involving the temporal bone. In two children, the loss was considered to be of allergic origin. In the group of 67 children who had a congenital nerve deafness, no definite cause could be found in 42 (62 per cent), but other associated factors were present. One child had a congenital heart. At birth, one child developed a right-sided facial paralysis believed to be due to a blood clot on the brain. The paralysis cleared and later the hearing loss was noted. Of the remaining 25 children, hearing loss was suspected in 11 to be due to prematurity, in five to Rh factor and in nine to severe illness of the mother during pregnancy. The illness in these nine mothers had been German measles, poliomyelitis, influenza, threatened miscarriage, uremia, hemorrhages, and hypertension. The mothers of three of the premature children had other complications: one mother developed diabetic coma, one severe toxemia of pregnancy and one mother had a placenta previa, and at birth the child was put in an oxygen tent and given

The Author
J. LEWIS GILL, M.D.



Doctor Dill is Chairman, Department of Otolaryngology, Henry Ford Hospital.

streptomycin. In the total group of 67 children with congenital nerve deafness, 11 had evidence of cerebral palsy, mental retardation, or were considered athetoid.

The hearing loss in congenital deafness is usually much more severe than in acquired. Of the 67 children with congenital nerve deafness, five had profound loss, 33 marked loss, 22 moderate loss, five mild loss, and two congenital ear deformity. In this last group, one child had a congenitally deformed left ear with complete loss of hearing and normal hearing in the right. The other child had a bilateral deformity with marked nerve deafness in the left ear and a mild loss in the right.

The diagnosis of a nerve or perceptive loss of hearing in a child can only be made after the tabulation of a good history, which includes complete and thorough examination of the ears, nose, throat, and sinuses, and a competent reliable hearing evaluation. The tests for impaired hearing must include pure tone air and bone conduction and speech audiometry by a competent audiologist when possible, and these tests verified by tuning fork tests done by the otologist. The pure tone audiometric test must be accurate and verified by a repeat test when doubtful. The congenitally deafened child who lacks hearing, and perhaps understanding, may be difficult for the average otologist to test in his office. The very young or handicapped child may require special testing with musical toys and noise makers. In addition, it may be necessary to utilize the skin galvanometric test in order to arrive at the basic threshold for hearing in these children. Many children present a special problem and should be referred to a large otological center where a complete evaluation can be more readily and competently accomplished. It is wise to examine all children with impaired hearing at as early an age as possible to make a diagnosis and institute therapy.

The treatment of all children with a nerve deafness is limited, but many methods are available to help overcome the handicap of the loss of hearing. There is no specific therapy, medical or surgical, available to improve a nerve type of hearing loss. As otologists we must recognize a child handicapped by a hearing loss, and not only treat the child, but also advise the parents about their deaf child. It is indeed wise to have all deaf children examined by a pediatrician with special reference to the child's general health, intelligence, and other defects that may be present. A thorough appraisal of the child as an individual and special evaluation of the hearing loss will enable the otologist to intelligently advise the parents in their future care and education of the deaf child.

Advice to the parents involves many factors, chief of which are the following: recognition of the handicap produced by the hearing loss; treatment of the child, as far as possible, as nonhandicapped; education of the child immediately at home, and early formal education—at the age of three when possible; utilization of a hearing aid when indicated and special schooling for the older child, including preferential seating, auditory training and lip reading; consultations between the parent and teachers regarding progress of the child; re-examination of the child's hearing when indicated, at least yearly. The totally and profoundly deaf child should be educated in a school for the deaf. The moderately or slightly deafened child should, if possible receive his education in the public school.

In our group of 93 children, approximately 40 per cent were seen before five years of age, and formal education was begun as soon as possible. Of the 67 children with congenital nerve loss 48 were fitted with hearing aids, six were advised admission to the school for the deaf and 13 were given advice and requested to obtain special auditory training. Of the 26 children with an acquired nerve loss, three had a mild loss and advice was given to the parents only. Five were advised special training, six children with a unilateral loss were advised preferential seating at school, 11 were fitted with a hearing aid, and one child with evidence of brain damage was considered a special case and specialized educational program advised.

Summary

A group of 93 children with nerve deafness were seen and treated. This group comprised 67 children with a congenital deafness and 26 with an acquired deafness. Of the total, 50 per cent of those with congenital deafness were seen before the age of five years, but only 23 per cent of those with acquired nerve deafness were seen before that age. The causes of the hearing loss were many and varied and were determined in approximately 73 per cent of those with acquired deafness and 38 per cent of those with congenital nerve deafness. The congenitally deafened child had, as a rule, a greater loss of hearing than the child with an acquired loss, and a greater number were fitted with a hearing aid. A hearing aid was advised and fitted in 59 children, 63 per cent of our total group. We found 11 (16 per cent) of the congenitally deafened children with evidence of cerebral palsy, mental retardation, or considered to be athetoid. This special group of 11 greatly handicapped children necessitated the advice and help of the parents, the otologist, the audiologist, the pediatrician and the teachers, with the co-ordination of a social service worker.

Parental Attitudes in Child Development

Benjamin B. Stamell, M.D.
Detroit, Michigan

BECOMING an emotionally healthy adult is a process of gradual maturation. The ability to assume responsibilities that face every grown-up individual does not suddenly occur when voting age is achieved, but rather is a situation of slow adjustment to the conflicts and rebellions that begin at birth and continue through life. Much of the end result depends upon the ground work and preparation laid in infancy and early childhood. Thus the role of the parent becomes of prime importance.

What, then, is necessary to provide for the development of well adjusted, reasonably efficient and happy children? What are the qualities and attitudes that parents must foster in order to provide for an atmosphere in which children may flourish? What must they know about their children to provide them with this wholesome environment?

Basically, every child needs the affection of both its parents. The infant definitely needs the tender care of the mother, and a sense that father stands with her in providing emotional support. The comforting bodily contacts of the nursing infant with the mother, her prompt response to satisfy his needs and wants, and later the loving solicitude of both parents help give the child a feeling of security and well being.

It may be said that the first step in the healthy emotional development of the child is the capacity of the parents to give love, and in return that the child himself senses this love. During this early period, the child is completely dependent on them for his safety and comfort and he should be aware that his parents are available in time of need. Therefore, if his dependency upon them is satisfactorily fulfilled, he will be comfortable and friendly; if it is not adequately met, he becomes tense and anxious. Parental affection is then the foundation upon which the child's feeling of security in life is built.

The emotional tie which is established with his parents in childhood greatly determines the individual's relationship with people in later life. It is from experiencing sympathy, understanding, patience, fairness, and encouragement of a wise parental love that the child is given a foundation for his later social attitudes. When the parent-child relationship is sound and wholesome, mistakes in the child's management are not likely to result in any serious or permanent harm to him.

Parents must provide an assurance of the stability of the home, for the child needs the protection of a firmly rooted environment. He needs confidence in their judgment. He should know that they will not make demands on him which he cannot meet. He must feel that they want him, and love him whatever his faults or shortcomings. His home must be a dependable refuge where he can return after his excursions into the outside world. There he can find understanding and counsel, and above all, emotional support, so that he can go forth again confidently to look for further experiences.

When a child learns by day to day contact with his parents that adults are tolerant and accepting people, even though at times they impose some restrictions, he will turn to new contacts with other adults and other children with a confidence that could only be the result of earlier experience. If a child is convinced that his parents are friendly and reliable people, then he himself inevitably adopts their attitudes. The child who feels reasonably secure in his parents faces his problems with straightforwardness and self confidence. He is curious. He displays a desire for new experiences, a striving for self-enrichment and a pleasure in accomplishment. To him, the world is intriguing and challenging.

Acceptance of the individuality of each child is another basic need. Comparisons of one child with another is a common experience, and when a parent cannot accept the limitations of his offspring, problems frequently result. It is quite natural for them to

The Author
BENJAMIN B. STAMELL, M.D.



Doctor Stamell is Psychiatric Consultant, Macomb Child Guidance Clinic.

want to create a child of whom they can be proud. But they must not apply too strict standards in the training of the child. How much better it is for children, when parents accept them as they really are, correctly evaluate their assets and liabilities, devise opportunities for them to make the most of what they have, allow them to develop at their own rate, and let them participate as well as they are able in the plans for their own activities and their own futures.

Parents can give children feelings of self respect and self esteem. They strive actively for these feelings. Confidence is built up within children by two types of experience: first, the satisfaction which comes from achievement; and second, the pleasure which results from the recognition of these achievements. Children must learn to sense their own worth. Anything which tends to make them feel unworthy or inferior is likely to evoke promptly some kind of defensive reaction. If children are unsure of themselves as persons in their own right, they may withdraw from social relationships in order to maintain their own sense of security by avoiding the hazards of group participation.

Recognition and approval for desirable behavior by parents have a great constructive value in child training. The attitudes which adults display toward a child's efforts are the chief means by which he can evaluate his own capacity and ability. It also determines the degree of satisfaction which he experiences in adopting a more adult type of behavior. When parents display interest in the child's activities and pleasure in his accomplishments, even routine tasks which he would otherwise consider as drudgery become not only tolerable but a matter of pride. Foundations for the later feelings of responsibility are thus laid.

A goal for parental management, then, is for each child to become an adult who can live happily and effectively in a competitive world. To accomplish this, the child must be nurtured and protected until he is capable of handling situations for himself. Protection, of course, can be over done or unduly prolonged, and the overly protected child may reach adult life unprepared to face the uncertainties and hazards which all adults must accept.

Properly timed, a feeling of insecurity may be character building. The value of such insecurity, however, depends on proper dosage; too much may defeat the purpose and result in unhappiness, and possible breakdown, and leave the child to enter adult life without confidence and faith in himself.

Parents must recognize a child's need for increasing independence. The infant, of course, is totally dependent upon his parents. However, every parent must realize that the day will come when their helpless child must become an emotionally mature adult who can stand on his own feet and win for himself a place in the professional, economic, and social world.

The ability to assume this responsibility is not a sudden acquisition. Rather it is the result of a process of growth, training and experience throughout childhood. In late infancy, the need for independence becomes evident when the child discovers that he has a will of his own. He then enjoys exercising it by making his own decisions, participating in plans for himself, and resisting plans which are imposed upon him.

Parents certainly may impose demands upon their children but at the same time be generous in allowing them to make less important decisions. Most children accept reasonable restrictions provided they have the repeated reassuring experience of having their own needs considered when major decisions are not at stake. However, it is important that children not be forced to assume responsibilities until they have the capacity to do so.

Children are as aware as adults that they do not have the ability to judge values in an adult world. They become frightened and confused if the occasion arises where they are required to form judgments in matters beyond their abilities, but they gain a sense of confidence if they can be free to make decisions in matters in their own sphere of action.

Proper credit for adaptability is not often given to children by their parents. The responsibilities the growing boy or girl assumes are generally taken for granted. If the demands made of them are excessive, they become, if not problem children, then at least children with problems. They react vigorously to unreasonable demands by becoming irritable, defiant, and tearful. There then develops antagonisms and hostilities which could have well been avoided by understanding and patience.

Summary

The mature individual represents an accumulation of many experiences. Stresses and strains from which he had been protected as a child have slowly brought increasing pressure upon him as he ages. The manner in which his parents handled these conflicts, and their reactions to them, largely, determine his basic personality. If they have given him strength and confidence, he will resolve his problems in a satisfactory manner; if they have not given him these qualities, he may resort to many neurotic artifices during his lifetime.

(Bibliography is on Page 912)

Systemic Sulfonamide Treatment of Infected Acne And Other Pyodermas

Andrew E. Segal, M.D.
James R. Rogin, M.D.
Detroit, Michigan

NUMEROUS diseases encountered by the dermatologist are either primary infections with bacterial organisms or are secondary bacterial infections complicating a primary non-infectious dermatosis. It is the considered opinion of many investigators[1-3] and probably the experience of most dermatologists that, in such instances, systemic antibacterial medication is one of the most effective combative measures. The more promptly the infection is controlled, the less is the likelihood of permanent tissue destruction with scarring. Since 1959 we have been using Madribon* (sulfadimethoxine), a long-acting sulfonamide, to control pustular skin disorders and have found it of great value in the treatment of these conditions.

Chemically, Madribon is 2,4-dimethoxy-6-sulfanilamido-1,3-diazine. It has a broad spectrum of antibacterial activity. After oral administration, peak blood levels are reached in four to 12 hours (depending on dosage) and the half-life of the drug is 34 to 38 hours.[4] The drug is excreted largely as the highly soluble glucuronide,[5] eliminating the danger of crystallization in the renal tubules.

The following report summarizes our use of Madribon over a three-year period (1959 to 1961 inclusive) in a total of 463 dermatological patients. While others[6-8] have reported on the successful use of Madribon in infected dermatoses, we believe our experience, both because of the large number of patients involved, and the length of the period over which they were studied, merits reporting.

Materials and Methods

All patients were evaluated with reference to side effects due to Madribon and 425 patients were evaluated for therapeutic response to Madribon as the main or adjuvant therapeutic modality. There were 285 patients with acne vulgaris in which a pustular element was present; 67 patients had pyodermas; 22, folliculitis; 12, furunculosis; 10, impetigo; 10, dyshidrotic eczema with secondary pyoderma; and the remainder (19) of the 425 had a variety of diagnoses (Table I).

The average treatment regimen was: 0.5 gm. twice daily for 2.4 weeks, followed by 0.5 gm. daily for 4 weeks, for a total of 6.4 weeks. Thus, the initial period of treatment employed the dosage recommended for "severe infections," i.e., 1.0 gram daily; and the longer course of therapy employed the dosage recommended for "mild infections." Several patients took Madribon for as long as 20 weeks.

Evaluation of results was based on response of pustular lesions while on medication. Those patients who showed rapid (within one week) and complete (or almost complete) clearing of the pustular element were classified as having an excellent response. Those patients who showed a slower response (one to three weeks) and/or who showed significant improvement in the pustular element were classified as having a good response. The remainder were classified either as poor or absolute failure.

Results

Of the 285 acne patients 88 (30.9 per cent) had an excellent response, 141 (49. 5 per cent) had a good response, 34 (11.9 per cent) a poor response, and 22 (7.7 per cent) failed to respond to therapy. Thus, in 80 per cent of the cases, Madribon was of value in the treatment of the pustular element of acne. The significance of these results is enhanced greatly when it is considered that it is largely the pustular element which is responsible for the scarring sequelae of acne as well as the disfigurement experienced by the patient during the active disease.

Considering the remaining 140 patients as a group, response to treatment was rated as excellent in 75



Author
ANDREW E. SEGAL, M.D.

*Roche brand of sulfadimethoxine, Hoffmann-La Roche, Inc., Nutley, N. J.

(53.6 per cent), good in 53 (37.9 per cent), poor in five (3.6 per cent) and failure in seven (5 per cent). While on treatment with Madribon, over 90 per cent of this group of patients responded favorably enough to be rated as excellent or good.

tient in our study was just over six weeks, our experience with the drug was over a three-year period. During that time we did not note any diminution of effectiveness either due to a development of resistant organisms or to any other cause.

TABLE I. RESULTS OF MADRIBON THERAPY IN PATIENTS WITH INFECTED ACNE VULGARIS AND OTHER BACTERIAL DERMATOSES

Diagnosis	No. of Patients	Response			
		Excellent	Good	Poor	Failure
Acne vulgaris	285	88 (30.9%)	141 (49.5%)	34 (11.9%)	22 (7.7%)
Pyoderma*	67	34	31	1	1
Folliculitis	22	11	10	1	0
Impetigo	10	9	1	0	0
Furunculosis	12	8	2	0	2
Infectious eczematoid dermatitis	8	4	3	0	1
Hidradenitis suppurativa	4	4	0	0	0
Dissecting cellulitis of scalp	1	1	0	0	0
Dyshydrotic eczema with secondary pyoderma	10	2	3	2	3
Acne rosacea pustular	6	2	3	1	0
Subtotal	140	75 (53.6%)	53 (37.9%)	5 (3.6%)	7 (5%)
Total	425	163 (38.4%)	194 (45.6%)	39 (9.2%)	29 (6.8%)

*The term pyoderma is used to include secondarily infected dermatoses, secondarily infected cysts, etc.

Of the 463 patients who were evaluated for reactions due to Madribon, none manifested any severe reactions. All were classified as minor, and were completely and rapidly reversible on discontinuation of the drug. There were 10 patients (2.2 per cent) who manifested some type of skin reaction. In one patient, there was generalized pruritus and burning of the oral mucosa, with no skin eruption. The other nine had erythematous, maculo-papular or morbilliform eruptions. Nine patients (2 per cent) experienced the following minor side effects, either alone or in combination: headaches, nausea, vomiting, dizziness, and "poor coordination" with weakness. In two patients, readministration of the drug caused a return of side effects; one patient tolerated 0.5 gm. daily but 1 gm. daily caused vomiting. Several patients took Madribon for as long as 20 weeks with no untoward reactions. With one exception, all reactions manifested themselves within the first two weeks of treatment. Of these, 50 per cent of the reactions were manifest within the first week. The one exception was a 22-year-old woman who developed a generalized morbilliform eruption after a total of 10 weeks of continuous therapy.

Comment

The large number of patients involved in our study enhances the statistical reliability of the results which indicate that Madribon is a highly effective and safe drug for the treatment of patients with pustular dermatoses. Although the average treatment period per pa-

Summary

Over a three-year period Madribon was administered to 463 dermatological patients with either primary or secondary bacterial infections. All patients were evaluated with reference to side effects and 425 patients for therapeutic response to Madribon. The average treatment period was between six and seven weeks. Dosage was 1 gm. stat and 0.5 to 1 gm. daily.

Of 285 patients with pustular acne, 80 per cent had a good to excellent response to therapy, i.e., complete or almost complete clearing of the pustular element in one to three weeks.

Of 140 patients with a variety of diagnoses including pyoderma, folliculitis, impetigo, and furunculosis, 91.5 per cent had a good to excellent response.

Minor reactions were experienced by 19 of the 463 patients and were completely and rapidly reversible on discontinuance of the drug.

The excellent results achieved in this study recommend Madribon for use in therapy of infected dermatoses.

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Medicine Needs General Practice

By F. P. Rhoades, M.D.
Detroit

Once almost all physicians in America were general practitioners. As recent as 1950, one-third of all graduates entered general practice. Today, only some fifteen per cent enter this most essential field. Unless means are found to reverse this trend, soon all graduates will choose a specialty or even a subspecialty. This will increase medical care costs beyond acceptable limits and hasten the advent of socialized medicine with its deadening bureaucratic controls and minimum standards of care.

Many of the first recruits to the ranks of the specialists were mature physicians who, after years of general practice, developed special skills and interest in certain fields. Their experience gave them a broad background of reference in which to practice their chosen specialty.

Today, the number of specialists, well trained primarily in their specialty, far exceeds the legitimate demands of society. Consequently, many of them are impelled through economic necessity to devote a large share of their office hours to general practice, a field for which they are ill-prepared and in which they have little interest.

When a specialist accepts a patient, he is both ethically and legally obligated to exhaust the gamut of applicable procedures in order to determine if the case falls within his domain. This is not only expensive but frequently unnecessary. By contrast, the generalist needs only to make the few relatively inexpensive tests indicated to arrive at a decision of whether or not the patient can be adequately treated by him or needs to be referred to the appropriate specialist. Only through this method of handling the host of complaints met with in every day practice can the total cost of medical care be kept within the limits acceptable to the American public.

Evidence is mounting that organized medicine, at long last, is recognizing that drastic measures must be taken if

general practice is to survive and continue to perform its historic role of effectively caring for the vast majority of human ailments in both a humane and economical manner. With this in mind the A.M.A. House of Delegates at Atlantic City adopted the McCreary Report reiterating that G.P.'s should have the opportunity to be active staff members of hospitals with the extent of their privileges based solely "upon training and demonstrated skills and abilities."

A resolution designed to accomplish as many revolutionary reforms in the field of medical practice as the Flexner Report did in the field of medical education also was adopted by the A.M.A. delegates. It instructed the Board of Trustees to appoint a commission with broad and sweeping powers to "study and recommend methods for the better distribution of knowledge and skills by the medical profession to provide more adequate availability of personal physicians."

In another resolution, the Board of Trustees was instructed to "utilize all facilities at its command" to request medical schools to "expose medical students to general practice by lectures, preceptive programs, and clinical instructors who are practicing general practitioners" and "inform the constituent state medical associations of the need to emphasize general practice training and to ask these association's members to encourage students to go into general practice."

If all branches of organized medicine can be convinced of the essentiality of adequate numbers of well trained general practitioners, and move with alacrity to implement the resolutions adopted by their delegates then, and only then, can the present system of independent private practice of medicine endure in America.

Community Health Councils In Michigan

Gordon H. Scott, Ph.D., President, Michigan Health Council

The importance of local community health councils was stressed at the 1963 State Health Conference, sponsored by the Michigan Health Council.

Many of the medical and lay speakers at the Community Health Day Program as well as at the Student Health Day Program gave reports of the success they have had in improving community and school health programs through their respective small and large community health councils. Many attested that one of the best mediums they had been able to find for centralizing and channeling activities of interested citizens and organizations toward the goal of better health was through their community health council.

Over 70 community and school health councils now exist in Michigan and are chapters of the Michigan Health Council. The State Council provides them with free packets of health information booklets, films and other materials from the state and national medical, dental, pharmaceutical organizations as well as other voluntary and official health agencies.

A community health council is composed of representatives of medical, dental, pharmaceutical and veterinary groups as well as of voluntary health agencies such as tuberculosis, cancer and heart associations, parent-teacher associations, schools, farm bureaus and granges, the health department, auxiliaries, hospitals, business and industrial organizations, service clubs and other groups with a major interest in the health of the people of the community.

A health council provides a medium through which physicians may provide medical and health guidance. Not a health agency which performs any actual services, a health council exists to coordinate the health resources of a community in a manner which will best meet the needs of that area. Such a council studies local problems, selects two or three major areas which need attention, and stimulates action by those most directly concerned. It also serves as a clearing house for medical and health information, preventing misunderstandings and eliminating duplication of efforts.

Each doctor should see the opportunities that a health council can provide in his community. Any member of MSMS, the State Woman's

Auxiliary, the State Medical Assistants and other groups may obtain information by sending a postcard or letter to the Michigan Health Council, 712 Abbott Road, Box 431, East Lansing.

More About Your Medical Assistant

By Esther G. Bartlett, President
Michigan State Medical Assistants Society

An employee in the office of an M.D. in Michigan has the privilege of membership in the Michigan State Medical Assistants Society, through their county organization.

There are twenty-four county organizations in Michigan, and two more are soon to be organized. This encompasses nearly 1000 members. Further, there are over 10,000 members of the American Association of Medical Assistants in the United States.

That many women with a purpose cannot be ignored!

We believe we are fulfilling a most important role in our jobs of assisting our doctor bosses in their daily tasks of healing, teaching and counseling. First and foremost, we want to make his task easier. We want to help him retain the image of the great man he is for which he has worked hard. Our loyalty to him and his patients is a firm fact.

The Michigan State Medical Assistants Society endorses and encourages its members to further education through the In-Service Training Programs now existing in nine counties and through various seminars and workshops throughout the state.

The American Association of Medical Assistants has diligently worked for the past three years on a certification program and the first candidates will be examined in the fall of 1963.

A certified medical assistant means to you, doctor, a diligent, intelligent, interested and well-trained person in either the technical or secretarial areas of your medical practice. She will have a very definite place in the future of medicine, by YOUR side!

Encourage your medical assistants to seek out the county organization and become a part of it.

States Support AMA-ERF

Michigan is among the leading states in providing financial support for the AMA's Education and Research Foundation. When the Michigan State Medical Society House of Delegates last fall voted a one-time $10 assessment for every member, Michigan joined with five other states that have had mandatory dues assessments. The others were California, Illinois, Indiana, Nevada and Utah.

The AMA reports that the New Jersey State Medical Society has made a grant of $5 per member, each year, from the Society treasury. The AMA also reports that Connecticut, Georgia, Maryland, New York, Oregon, South Carolina and West Virginia have sent their members either a separate statement concerning contributions for AMA-ERF or have included such an item on their bills for dues.

Across the nation, thousands of medical students, interns and residents are paying for a substantial part of their training for drawing on this AMA-ERF loan fund.

AMA-ERF's plan is not a sleight of hand. The only "magic" lies in the fact that every dollar contributed to the program's loan guarantee fund releases $12.50 in bank credit. So great has been the response to the program that one of every ten medical students in the country already is a borrower.

Physicians and private industry throughout the nation have been giving generously to the fund with the knowledge that their contribution dollars can stretch far beyond their face value in helping determined students become the physicians of tomorrow. This AMA project can succeed only through the continued support from the entire medical profession in the nation.

Tributes to Wilfrid Haughey, M.D.

Two Battle Creek doctors, who knew Doctor Haughey well, were requested to write short tributes for this number of THE JOURNAL. A brief article appeared in the In Memoriam section of the August number.

Medical Statesman and Editor

By Sherwood B. Winslow, M.D.

A brilliant career in the fields of medicine and journalism ended July 12, 1963, with the passing of Wilfrid H. Haughey at the age of 82.

A graduate of the University of Michigan where he received his A.B. degree in 1904, he entered the Detroit College of Medicine and graduated there in 1906. After an internship in Detroit, most of it at Harper Hospital, he returned to Battle Creek to enter private practice in 1910. He was editor of THE JOURNAL of the Michigan State Medical Society from 1910 to 1913 after a four-month session of editing THE JOURNAL in 1906 when the editor was ill. He resumed this position in 1942, and served until his death.

In May, The MSMS Council named Doctor Haughey as first Editor Emeritus of THE JOURNAL and awarded a citation. Due to his critical illness, his son Philip accepted the citation on his behalf in a brief ceremony at Leila Hospital. Informed later of the honor, Doctor Haughey showed his appreciation and pleasure, according to George W. Slagle, M.D., a past president of the MSMS, who made the presentation.

Doctor Haughey served the Calhoun County Medical Society as secretary for many years, then as president and later became Third District Councilor. He was one of four Battle Creek physicians who pioneered (1931) the first prepayment health insurance plan for Michigan, which after long consideration was approved by the House of Delegates of the Michigan State Medical Society in its special meeting of January 8, 1939, and became Michigan Medical Service one year later. He later served the Blue Shield as a board member and president, and probably had the longest term of service of anyone with this organization.

Not only long active in Blue Shield, Doctor Haughey also served as MSMS representative on the Blue Cross Board of Directors from 1939 to 1948.

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"Mr. Blue Shield"

By George V. Slagle, M.D.

Behind the evolvement of Blue Shield in Michigan, in the past thirty years, there are the acts and deeds of many fine Doctors of Medicine, who not only had vision but also had the desire and willingness to work hard to fulfill a dream. One of these was Doctor Wilfrid Haughey.

From early 1931 when he, with a group of four other doctors in Battle Creek, first began to work on the possibility of some form of prepayment plan, until two weeks before his death on July 12, 1963, Wilfrid was in the forefront of the action to develop such a plan. First, the men in Calhoun County met obstacles in developing such a plan, and later joined forces with the Michigan State Medical Society to get an enabling act passed in 1939, that would permit the establishment of a non-profit prepayment plan. Prior to this, it was contrary to the insurance laws.

To attempt to chronologically list his contributions to Blue Shield in detail would entail more pages than are available. However, let us list a few of the major items.

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The Calhoun County Medical Society honored Doctor Haughey in 1960 on his 80th birthday with a special certificate of recognition. With him were G. Thomas McKean, M.D., *left*, then president of Blue Shield, and George V. Slagle, M.D., a past president of MSMS.

Medical Statesman and Editor (Cont'd)

He enjoyed the distinction of attending 50 consecutive annual meetings of the House of Delegates of the American Medical Association and was honored for this service at its 1960 meeting. Other honors included a golden diploma from Wayne State University School of Medicine in 1956. A special meeting of the Calhoun County Medical Society in 1960, shortly after his 80th birthday, offered testimony of his 50 years of practice in Battle Creek.

An outstanding honor was accorded Doctor Haughey in 1949 when he was voted MSMS "President-for-a-Day."

Doctor Haughey, the son of a physician who also practiced in Battle Creek more than 50 years, was the father of eight children who have made distinguished careers for themselves in their chosen fields. He was a member of St. Ann's Catholic Church at Gull Lake, the Battle Creek Kiwanis Club, the Athelstan Club and had headed the Queen City Council,



National recognition was accorded in 1961 when the State Medical Journal Advertising Bureau presented a plaque to Doctor Haughey at its conference in Chicago. The presentation was made by Walter E. Vest, M.D., Huntington, West Virginia. Seated is Theodore Wiprud, formerly with the *Medical Annals* of Washington, D. C. The SMJAB cited THE JOURNAL MSMS as one of the very best in the nation.

Knights of Columbus. For many years, he was an active member of the American Legion. Until recent years, he was a member of the Gull Lake Yacht Club.

Doctor Haughey was married June 27, 1907, to Edith Cowles of Greenville, whom he had met while both were attending the University of Michigan. Mrs. Haughey died March 11, 1955, at the age of 74.

A professional association is the voluntary uniting in an organization of men of like mind and qualifications. An Association can perform its duties only to a degree proportionate to the members' own support and participation. —ROBERT J. GILLESPIE, R.Ph., President, American Pharmaceutical Association, in July 6, 1963 *APha Newsletter*.

"Mr. Blue Shield" (Cont'd)

DOCTOR HAUGHEY was one of the original incorporators of Michigan Medical Service in 1939. He was elected Vice President in September, 1941, and filled this position until October, 1955, at which time he was elevated to the Presidency of Michigan Medical Service. He served as President of Michigan Medical Service from October, 1955 to October, 1956. At this time he was elected Honorary Chairman of the Board, which he held for one year and then in October, 1957, he was elected Honorary Chairman of the Board in Permanentia, which honor he held until his death.

In addition, for many years he served as a Michigan Medical Service alternate or voting delegate to the Annual Meeting of Plans, National Association of Blue Shield Plans. In 1953 he was voting representative to District 8 meeting.

He has served at one time or another, on every Committee of the Board of Michigan Medical Services.

WILFRID WILL ALWAYS BE remembered for the extensive and deep background he had in the development of the philosophy of prepayment plans. We who have served with him through the years have always respected his innate ability to call upon the past for a solution of the present. Michigan Medical Service was a definite, integral part of Doctor Haughey's life. Up to within a short time before his death, he was planning on attending the next Board Meeting.

Prior to his serious illness in September, 1962, Wilfrid had not missed more than one or two Board Meetings throughout all the intervening years.

His devotion to Michigan Medical Service, with those of his confreres shall not be forgotten. Let us pray that it will not have been in vain.



A citation honoring Doctor Haughey as the first Editor Emeritus of THE JOURNAL was presented by MSMS in the hospital corridors to the family July 9. The family reported that Doctor Haughey was pleased to receive the honor. Shown, *left to right*, are William A. Scott, M.D., Chairman of the MSMS Publications Committee; Phillip Haughey, one of Doctor Haughey's sons; George V. Slagle, M.D., past MSMS President, and Harvey C. Hansen, M.D., Battle Creek, MSMS Councilor for Doctor Haughey's district.

MICHIGAN DEPARTMENT OF HEALTH
ALBERT E. HEUSTIS M.D., State Health Commissioner

Hospital and Medical Facilities

Since 1947, the federal government has assisted in the construction of hospitals and other medical facilities through a grant-in-aid program known as the Hill-Burton Act. In Michigan, the program is administered by the state health department's Division of Hospital and Medical Facilities which annually disburses some seven million dollars for the construction of needed medical facilities. The keystone of the program is a comprehensive state plan revised every year.

When the program first got underway in 1948, Michigan had only 51 per cent of the needed acceptable beds in general hospitals, and 27 of the 71 hospital service areas had no acceptable hospital facilities at all. Today, we have 81.5 per cent of our needed general hospital beds and there are only six hospital service areas which have less than 60 per cent, while only three have no acceptable facilities whatever. Since the start of the program 126 hospital projects have added 7,663 beds at a cost of over $156,000,000 of which federal funds have contributed nearly a third. In addition, 55 other medical facility projects including psychiatric facilities, public health centers, long-term care facilities, and schools of nursing have added another 2,034 beds at a cost of $38,000,000.

The accompanying chart summarizes all projects assisted by Hill-Burton funds in Michigan from the start of the program through June 30, 1963.

Although significant progress has been made in the past 14 years, it has been primarily a matter of catching up with the needs. We are still 18 per cent short of the number of acute care hospital beds. However, in recent years the program emphasis has shifted to long-term care and psychiatric facilities where an even greater gap exists between needed and available beds. As a result, an increasingly greater proportion of grants have been allocated to construction projects in these areas. The problem of building for future needs of our increasing population places

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SUMMARY OF PROJECTS UNDER THE HILL-BURTON PROGRAM
1947 through June 30, 1963

	Total Projects	Number of Beds	Total Cost	Federal Share
General hospitals	126	7663	$156,418,717.00	$47,651,196.51
Psychiatric facilities	11	523	5,482,283.00	1,862,905.17
Separate hospitals	3	244	3,474,159.00	1,006,984.33
Units in general hospitals	3	279	1,036,767.00*	371,906.21
Mental health clinics	5	0	971,357.00	484,014.63
Tuberculosis hospitals	2	155	1,530,726.00	565,927.33
Schools of nursing	8	0	7,568,949.00	1,905,278.63
Public health centers	9	0	3,158,283.00	1,151,722.37
Separate units	5	0	2,446,642.00	872,102.62
In county buildings	3	0	504,206.00	196,999.94
In medical care facilities	0	0	150,254.00	63,212.95
In hospitals	1	0	57,181.00	19,406.86
Long term care facilities	21	1356	19,180,554.00	7,111,793.80
Rehabilitation centers	5	186	5,587,166.00	2,040,644.00
Units in general hospitals	5	293	5,213,517.00	2,301,100.15
County medical care facilities	11	878	8,379,871.00	2,770,049.65
Diagnostic and treatment facilities (Not part of general hospitals)	4	0	1,282,414.00	483,767.72
Outpatient facilities in hospital	2	0	939,879.00	349,245.72
Cobalt or supervoltage installation	2	0	342,535.00	134,522.00
Mental health clinics	Included above under psychiatric facilities			
Total projects	181	9697	$194,621,926.00	$60,688,591.53

*Costs included in general hospital.

First 50 Years Of MSMS—In Brief

This first article in the MSMS Centennial Series briefly traces the first half-century of history of the Michigan State Medical Society; it also discusses the two previous efforts to organize a medical society. The October Journal *will feature an article by Alfred H. Whittaker, M.D., Detroit, about the early discoveries of Michigan's William Beaumont, M.D., in human digestion. A series of monthly articles will begin in the November Number by William J. Stapleton, Jr., M.D., of Detroit, MSMS Historian, bringing the history up to the MSMS Centennial, which will be observed officially at the 1965 Annual Session in Detroit.*

This article was written by Herbert A. Auer, Managing Editor of The Journal *MSMS.*

When members of the Michigan State Medical Society gather in Detroit in 1965 to celebrate the Centennial Anniversary, the historic spotlight will focus back to the first annual meeting in 1866.

It was on June 5, 1866 when about 100 physicians traveled from across the state to Detroit to organize the "Michigan State Medical Society."

There had been two previous medical organizations in Michigan, but there had been breaks from 1851 to 1853, and then again in 1860.

So when the physicians gathered on June 5, 1866, it was appropriate for Morse Stewart, M.D., of Detroit, in his welcoming address to recall that:

"The profession had failed to promote properly the advancement of medical science, individual growth and development, and through these the great and ultimate object of our profession and the welfare of society."

Doctor Stewart made a strong appeal to the men, "that their hearts (be) expanded by an enlarged charity so as to exclude individual selfish aims, should we enter upon the duties which are before us."

The men elected Cyrus M. Stockwell, M.D., Port Huron, as president. Two of the original founders, Theodore A. McGraw, M.D., Detroit, and George E. Ranney, M.D., Lansing, were speakers at the 50th Annual Meeting in Grand Rapids, September 1, 1915.

Any review about the early history of the medical profession in Michigan must flash back to August 10, 1819 when the "Michigan Medical Society" was organized under Territorial laws. The Society with five members started that day, encouraged by John L. Whiting, M.D., who had reached Detroit on horseback in 1817 from New York, where he had been licensed. Doctor Whiting served long as secretary and then as president, and died at the age of 87.

The first officers in 1819 were headed by William Brown, M.D., as president. The Society had but five members with which to fill seven offices so two were given two offices each.

Leartus Connor, M.D., MSMS president in 1902, in his Presidential Address that year, dealt with the early Society efforts. In part,



First MSMS President

Cyrus M. Stockwell, M.D.
Port Huron (1866)

he said, "Recalling that, quacks included, there were but eight doctors in Detroit and scarcely more in the Territory, it called for a sublime faith in these five doctors to form a medical society on the basis of ensuring a clean, well-educated, honest profession in Michigan."

(The Detroit population in 1820 was 1,442)

The Incorporating Act in 1819 specified that "the Society president, senior censor and secretary shall form a board to examine students in the preparatory branches of education and give a certificate previous to their entering upon the study of medicine."

The medical law was amended in 1825 and 1829; and then revised in 1838 when public sentiment ran high against the many quacks who came to the new state. The population rose from 7,000 in 1820 to 174,000 in 1837. Dr. Connor in his 1902 address vividly drew the picture of that period:

"It was a period of wild-cat money, of general extravagant inflation of everything, the projection of public and private enterprises on a scale paranoiac. As the people were in a frame of mind to be robbed, the quacks gathered to do the job in accord with the axiom, 'where the carcass is there do the vultures gather.'

"In 1846, Physicians from other states were admitted to practice without any formalities—thus for the first time inaugurating the era of 'free trade' in medical practice, an era unchecked until a recent date.

"Perhaps the most remarkable thing in this history, as related by Dr. Zina Pitcher, is a decision of the Michigan Supreme Court that 'A doctor is any person calling himself such'."

The changes of officers in this Society were very infrequent. William Brown, M.D., was president seven years; William Thompson, M.D., one year; Stephen C. Henry, M.D., six years; John L. Whiting, M.D., three years; Marshall Chapin, M.D., one year; D. V. Hoyt, M.D., one year, and Zina Pitcher, M.D., fourteen years—seven presidents in thirty-two years.



Leartus Connor, M.D.
Detroit (1901)



Reuben Peterson, M.D.
Ann Arbor (1914)

Four men served as secretary during the first 32 years—John L. Whiting, M.D., eleven years; Randall S. Rice, M.D., seven; E. M. Cowles, M.D., one, and J. B. Scovell, M.D., fourteen.

"A notable event in the Society's history was the election to membership of Dr. William Beaumont, of Mackinac on June 14, 1825. On August 27, 1826, he gave the Society a report of his celebrated case of gastric fistula, with an account of clinical and chemical studies on gastric digestion, scientific observation, which formed an epoch in our knowledge of human digestion.

"Licensed physicians in any county, on application, were granted by the territorial society the right to form a local society which, within the limits of the county had the same rights as the territorial, except that the aggrieved member had the right of appeal to the parent society, and the county society was compelled to accept the decision as final.

"On June 12, 1827, permission was granted Drs. Cyril Nichols, Rufus Pomeroy, William Kitteridge and David Lord to form a Washtenaw County Medical Society.

"On June 12, 1831, permission was granted Drs. William Thompson, David L. Porter, E. L. Parke, and Thaddeus Thompson to form an Oakland County Medical Society.

"On July 23, 1835, to Dr. Hubbel Loomis, et al., to form a St. Joseph County Medical Society.

"In January, 1836, to Dr. L. T. Jenney, et al., to establish a Macomb County Medical Society.

"In January, 1836, to establish a Monroe County Medical Society.

"In June, 1837, to Drs. Darwin Littlefield, Hiram Alden, M. Randall, William Noneclott and Thomas Caulkins to establish a Branch County Medical Society.

"On April 14, 1849, the Wayne County Medical Society—From an unpublished report of a meeting of this Society, March 16, 1850, it was reported that 'Edmund Andrews is entitled to be received as a student of medicine by any member of the Wayne County Medical Society.' Thus one of Chicago's most celebrated surgeons gained permission to begin the study of medicine from this Society.

During this period, the old Michigan Medical Society limited itself largely to the execution of state laws regulating the practice of medicine, doing little to develop its members along scientific or literary lines, or to foster or develop county societies.

The second phase of the MSMS history started with a meeting at Ann Arbor, March 30, 1853, and ended on March 30, 1860. The group in 1853

organized as the "Peninsular Medical Society," formed primarily for the advancement of medical science. Action of the State Legislature in 1851, when it abolished all medical laws, inspired some of the doctors to meet in 1853—many of them eager to assist the young medical department started at the University of Michigan in 1849.

Serving as president during this period were George Landon, M.D., Monroe; Henry Taylor, M.D., Mt. Clemens; Zina Pitcher, M.D., Detroit; J. H. Beech, M.D., Coldwater; N. B. Stebbins, M.D., Detroit; J. Adams Allen, M.D., Kalamazoo, and H. B. Shank, M.D., Lansing.

Edmund Andrews, M.D., of the University medical school, served as secretary for several years and as editor of the "Peninsular Medical Journal."

The organization had grown to 115 members when its eighth annual meeting was called at Coldwater for January 18, 1860. So few were present that it was adjourned to Ann Arbor for March 29. Again, few doctors attended and it disbanded.

"Circumstances, not the workers, were responsible for its quiescence from 1860 to 1866," declared Reuben Peterson, M.D., Ann Arbor, in his Presidential Address at the 50th Annual Meeting in 1915. Doctor Peterson pointed out another deterrent:

"Moreover, it must not be lost sight of that the approach of the Civil War probably was one of the principal reasons for lack of interest in the new State Medical Society. Once the war had begun, even a flourishing medical organization would have been temporarily abandoned."

Historic records show a sharp contrast between this second period as contrasted to the territorial organization. The work of the first was entirely executive, having to do with the regulation of medicine, but the second Society vigorously urged the members to observe the code of ethics of the American Medical Association, to observe, record and publish facts in its Peninsular Medical Journal, and to help the University of Michigan medical department improve its scholastic program. Doctor Peterson's speech summarized the period by noting that "the Society was distinctly alive to the public health of the state."

Just as conditions in the young nation worked against the medical organization during the Civil War, conditions worked in its favor when the present Michigan State Medical Society was organized in 1866. The end of the Civil War left many energetic young doctors in Detroit without adequate clientele and willing to contribute to the Society's efforts for clinical education and public service.

The Society efforts for proper and necessary state health department was a major contribution. Doctor Peterson observed that:

"The establishment of the State Board of Health would have been postponed to a much later date had it not been for the efforts of this Society. Individually and through committees, the members labored from 1870 to 1873 until the bill for the establishment of the Board passed the Legislature."

Many Michigan physicians active at the turn of the century have praised the work of Leartus Connor, M.D., who has been quoted in this article. Doctor Connor was president in 1901 and he appointed the committee that did much of the work leading up to the 1902 action which finally reorganized MSMS along the lines of a delegate body. It had been discussed at the annual meetings from 1885 until approved in 1902. W. T. Dodge, M.D., in a special historic Journal article in 1915 (the MSMS 50th anniversary) singled out Doctor Connor for special plaudits. He wrote: "Fortunately, the Society had (in 1901) for its President one who was eminently fitted for this special work—the late Leartus Connor. The heart and soul of this unselfish, great Michigan physician were absorbed in the work of perfecting an organization of his fellows that would in every sense of the word be representative of the entire profession of the state."

The first number of THE JOURNAL of the Michigan State Medical Society appeared in September, 1902 with Andrew P. Biddle, M.D., as the first Editor. Doctor Biddle also served as the Secretary of the Society then.

Many refinements were accomplished between 1902 and 1915. Doctor Peterson, as the 1915 annual meeting, declared that "The Society now is an efficient organization. Time formerly wasted in fruitless discussions by speakers poorly prepared is now profitably consumed by the qualified delegates of the county societies. The work of the executive committee of The Council, has demonstrated that men can be found who will give freely of their valuable time for the general good. Our Society is more than a group of physicians who meet once a year to discuss papers. It is a business organization as well, with many ramifications."

One of the questions raised by Doctor Peterson in 1915 at the 50th anniversary was, "Has the time arrived for a full-time Society secretary? I merely raise the question. It is for you to give the answer."

THE JOURNAL for August, 1915 carried an editorial by Andrew P. Biddle, M.D., about "The Medical Society of Tomorrow." Several quotations

will provide us an effective bridge into the future articles in this MSMS Centennial Series. Doctor Biddle wrote: "The county, state and national associations today are the centers of thought and action of the professions; but now with an enlarging and more exacting population the expectations of civilization of the profession have enormously increased, and the medical society of tomorrow must be ready to meet these expectations."

PAST PRESIDENTS

1866-1914

1866—C. M. Stockwell, Port Huron
1867—J. H. Jerome, Saginaw
1868—Wm. H. DeCamp, Grand Rapids
1869—Richard Inglis, Detroit
1870—I. H. Bartholomew, Lansing
1871—H. O. Hitchcock, Kalamazoo
1872—Alonzo B. Palmer, Ann Arbor
1873—E. W. Jenk, Detroit
1874—R. C. Kedzie, Lansing
1875—Wm. Brodie, Detroit
1876—Abram Sager, Ann Arbor
1877—Foster Pratt, Kalamazoo
1878—Ed Cox, Battle Creek
1879—George K. Johnson, Grand Rapids
1880—J. R. Thomas, Bay City
1881—J. H. Jerome, Saginaw
1882—Geo. W. Topping, DeWitt
1883—A. F. Whelan, Hillsdale
1884—Donald Maclean, Detroit
1885—E. P. Christian, Wyandotte
1886—Charles Shepard, Grand Rapids
1887—T. A. McGraw, Detroit
1888—S. S. French, Battle Creek
1889—G. E. Frothingham, Detroit
1890—L. W. Bliss, Saginaw
1891—George E. Ranney, Lansing
1892—Charles J. Lundy, Detroit
(Died before taking office)
Gilbert V. Chamberlain, Flint
(Acting President)
1893—Eugene Boise, Grand Rapids
1894—Henry O. Walker, Detroit
1895—Victor C. Vaughan, Ann Arbor
1896—Hugh McColl, Lapeer
1897—Joseph B. Griswold, Grand Rapids
1898—Ernest L. Shurly, Detroit
1899—A. W. Alvord, Battle Creek
1900—P. D. Patterson, Charlotte
1901—Leartus Connor, Detroit
1902—A. E. Bulson, Jackson
1903—Wm. F. Breakey, Ann Arbor
1904—B. D. Harison, Sault Ste. Marie
1905—David Inglis, Detroit
1906—Charles B. Stockwell, Port Huron
1907—Hermon Ostrander, Kalamazoo
1908—A. F. Lawbaugh, Calumet
1909—J. H. Carstens, Detroit
1910—C. B. Burr, Flint
1911—D. Emmett Welsh, Grand Rapids
1912—Wm. H. Sawyer, Hillsdale
1913—Guy L. Kiefer, Detroit
1914—Reuben Peterson, Ann Arbor

Hospital and Medical Facilities

(Continued from Page 898)

severe demands on available funds, and consequently planning has become increasingly more discriminating.

As a result, the department promotes the concept of area-wide planning to make the most efficient and economic use of existing or proposed facilities while rendering adequate care for all of our people. Most significant perhaps is the newer concept of continuity of care: facilities which can provide a patient with continuous service from acute care through convalescence to recovery. Thus, today, smaller communities planning the development of medical facilities should include the coordination of acute and long-term care facilities, and the provision of outpatient facilities within the general hospital, and the larger hospitals should incorporate rehabilitation and psychiatric services.

By 1970, Michigan will have an estimated population of nine and one-half million and will need 39,000 acute care beds (12,000 more than presently available), and 29,000 long-term care beds (21,000 more than presently available). As our population increases the number of persons hospitalized each year goes up, although counteracted somewhat by a decreasing average length of stay in hospitals. In 1948, 82 out of every 1,000 Michigan persons were hospitalized for an average of 8.2 days; today 138 out of every 1,000 are hospitalized with an average stay of 7.3 days.

In the future, hospitals must be constructed and equipped to carry on health programs which include convalescent care, rehabilitation services, outpatient services, and even home care programs. Michigan communities must begin to think not just in terms of additional general hospital beds but of organizational arrangement and facilities to provide a continuity of care to most effectively meet the health needs of the community.

AMA-ERF Contributions Rising

Physicians in 1962 gave a record $1,461,811 to Funds for Medical Schools and more than $275,000 for AMA-ERF's Medical Education Loan Guarantee Program. Both Funds for Medical Schools and the Loan Program are important projects deserving of full support. AMA President George M. Fister, M.D., declares that for our medical schools "voluntary contributions with no strings attached are more significant today than ever before."

1963 MSMS Annual Session Scientific Exhibitors

S-I "The Physician's Role in the Fluoride Program"

F. J. Margolis, M.D., E. Freshman, M.D., J. Macaulay, M.D., Kalamazoo, Michigan

This exhibit shows why the physician should take an active part in the prevention of dental caries. It shows (1) that calcification of permanent teeth begins at birth (2) methods of reducing dental caries (3) results of fluoride programs (4) a long term research design to answer many of the remaining questions, included in the research design is an excretion study showing that fluoride given in water, as a tablet or in a vitamin-fluoride product have essentially an identical excretion pattern. The pattern of fluoride excretion is merely a function of the interval of administration. Data from the daily tap water intake study on 651 children indicates that the average infant or young child consumes a very minimal quantity of water. Children from 30 months to 8 years of age have an average daily tap water consumption of less than 500 cc.

S-II "Expanding and Ruptured Abdominal Aortic Aneurysms"

D. Emerick Szilagyi, M.D., Roger F. Smith, M.D., Joseph P. Elliott, M.D., Henry Ford Hospital, Detroit, Mich.

Although the diagnosis of expanding and ruptured aneurysm of the abdominal aorta presents no great difficulties and can virtually always be made with accuracy on purely clinical grounds, a distressingly large number of such cases have come to our attention in which the correct diagnosis had been missed or excessively delayed. A survey of 200 aneurysms of the abdominal aorta treated surgically (of which about one-third were either expanding or ruptured) disclosed that these errors stem from the oversight of simple diagnostic clues and that the resulting delay in treatment is largely responsible for the high mortality rate of operations for rupture. By means of tables, artists' drawings and reproductions of roentgenograms, these findings are presented giving illustrations of the signs and symptoms important for prompt diagnosis and outlining some operative steps in the management of rupture that may assure speed in achieving the surgeon's goal (i.e., the stoppage of a catastrophic hemorrhage) and thus help increase the salvage rate of these desperately ill patients.

S-III "Recurrent Shoulder Dislocation: Anatomy; Pathogenesis; Pathology"

C. O. Townley, M.D., S. C. Walker, M.D., Port Huron Hospital, Port Huron, Mich.

S-IV "Comprehensive Health Appraisal—The Highest Skill in Medicine"

AMA Committee on Aging and MSMS Geriatrics Committee

This exhibit depicts the value to both physician and patient of a comprehensive health examination, and outlines the important areas which should be covered in such an examination.

S-V "Milk Hypersensitivity—A Collaborative Clinical Biochemical and Immunological Study"

Armond S. Goldman, M.D., F.A.A.C.P., William A. Sellars, M.D., F.A.A.C.P., Peter B. Kamin, M.D., F.A.A.C.P., David W. Anderson, Ph.D., et al, The Borden Company, New York, New York

This exhibit will portray the clinical and serologic data which was obtained from 75 children with proven cow's milk allergy. These patients were diagnosed and studied by 17 collaborating members of the Academy of Pediatrics.

The objectives of this study were to determine (1) the relevant symptoms of milk sensitivity, (2) the allergens in cow's milk responsible for these reactions, (3) the relationship of skin testing with four isolated milk proteins to the results of their oral challenge, and (4) the serologic manifestations of milk allergy.

Patients were accepted as sensitive to milk on the basis of relief of symptoms during elimination of milk and reappearance of these same symptoms upon the reintroduction of the milk on a minimum of two occasions.

If a reproducible reaction could be produced by the oral administration of 100 ml. of skimmed milk, oral challenges with corresponding levels of casein, alpha-lactalbumin, beta-lactoglobulin and bovine serum albumin were performed to determine the relative allergenicity to each of these isolated and purified proteins. Each patient was skin tested with these proteins and a blood specimen examined for the presence of antibodies to milk proteins by the gel diffusion technique and the passive cutaneous anaphylaxis techniques in the guinea pig.

S-VI "Why Gout Should be Treated"

Richard T. Smith, M.D., Benjamin Franklin Clinic, Philadelphia, Pa.

S-VII "Skin: The Mirror of Age"

Committee on Cosmetics, American Medical Association, Chicago, Ill.

The exhibit "Skin: The Mirror of Age" discusses the changes and factors involved in the normal aging of the skin and includes appropriate photographs. Methods of management of the aging skin are discussed and illustrated.

S-VIII "Services in Cancer Control Provided by Members of the Michigan Cancer Coordinating Committee"

MSMS Cancer Control Committee and Michigan Cancer Coordinating Committee

S-IX "Fluouracil in Cancer: Indications, Method, Results"

Michael J. Brennan, M.D., Henry Ford Hospital, Detroit, Mich.

S-X "A Crystal Gallery of Medicine"

D. M. Robertson, Merck Sharp & Dohme, West Point, Pa.

This is an exhibit of the distinctive crystalline patterns of various compounds, including drugs of major importance in clinical medicine.

Like other crystals in nature, these are precise geo-

metrical formations. Each compound reveals its own molecular character. Each has a specific, recurring pattern, expressing its internal form—indeed, its spatial atomic arrangement.

Made under polarized light, these photomicrographs offer studies in composition, in color, and in contrasts appealing alike to scientists and artists. (From pictures of selected Merck Sharp & Dohme research products taken from Eastman Kodak Exhibit Center).

S-XI "Preschool Screening"

MSMS Child Welfare Committee and Michigan Department of Health

This exhibit, 10 feet long and 7 feet high, explains the need for early identification of vision and hearing losses in preschool children and shows how such losses can be found by mass vision and hearing screening tests carried out cooperatively by local health departments and local medical societies.

S-XII "Patient Test and X-Ray"

Michigan TB and Respiratory Disease Association and Michigan Thoracic Society

The exhibit promotes additional tuberculin testing of patients by physicians and stresses the importance of chest x-raying tuberculin reactors. It also refers to various groups of reactors who may need therapy or prophylaxis. Included is information on the proper dosage, technique and interpretation for tuberculin testing.

S-XIII "Mental Health Programs in Michigan—Examining the Present, Planning the Future"

Michigan Department of Mental Health

This display will feature a large state map with colored button-lights showing locations of state mental hospitals and community clinics. Special displays from state mental health facilities will point-up major programs of care, treatment, and rehabilitation for mentally ill and retarded patients. The importance of professional participation in planning future mental health programs and facilities will be highlighted.

S-XIV "Patient Safety in Hospitals"

Michigan Hospital Association and Michigan Department of Health

Using the theme that patient safety in the hospital is just good patient care, that accidents do happen and can be prevented with the appropriate action, the physician must assume leadership in this phase of care. Many hazards exist in front of our nose; 65% of patient accidents occur within ten feet of the bedside.

S-XV "Tranquilizers in Psychoneurosis"

John H. Nodine, M.D., John H. Moyer, M.D., Michael Barry, M.D., Mr. Courtney Franklin, Hahnemann Medical College and Hospital, Philadelphia, Pa.

S-XVI "Salvage of the Rheumatoid Hand"

James A. MacDonell, M.D., Grand Rapids, Mich.

S-XVII "The Use of Mannitol in the Prevention and Treatment of Acute Renal Failure"

Kevin G. Barry, M.D., Richard I. Mazze, M.D., William L. Parry, M.D., Antonio Boba, M.D., Samuel Powers, Jr., M.D., Walter Reed Army Medical Center, Washington, D.C.

S-XVIII "Diagnostic Radiography with Portable Radioactive Sources"

Kenneth L. Krabbenhoft, M.D., Department of Radiology, Harper Hospital, Detroit, Mich.

Diagnostic radiography with portable radioactive sources has been limited by inherent difficulties of radiation spectrum, half life, specific activity, availability, etc.

Recently Yb^{169}, Sm^{153}, Gd^{153}, Lu^{177}, Tm^{170} and I^{125} have been evaluated. The quality of radiographs obtained with these sources is presented comparatively, Yb^{169} affording those of best quality.

S-XIX "Learn Plastic Wound Closure"

Richard E. Straith, M.D., James M. Lawson, M.D., C. J. Hipps, M.D., Enrique Sabbagh, M.D., The Straith Clinic, Detroit, Mich.

Personal Instruction;

Fresh pigs' feet, instruments and sutures are provided to practice our technique of plastic wound closure. Four surgeons can practice simultaneously. Approximately ½ hour is required to learn the principles of the technique.

Before and after pictures of plastic surgical procedures.

S-XX "Do You Have A Question, Doctor?"

Michigan Chapter of the Arthritis and Rheumatism Foundation

A consultation booth has been arranged where visiting physicians may discuss problems regarding their patients who have arthritis. This booth is sponsored by the Michigan Chapter of the Arthritis and Rheumatism Foundation, and the consultants are members of the Michigan Rheumatism Society.

S-XXI "The Regulation of Dietary Fat"

Department of Foods and Nutrition, American Medical Association, Chicago, Ill.

This exhibit highlights the information given in the Council's report "The Regulation of Dietary Fat." The exhibit makes the following points: (1) content and role of fat in the U.S. diet, (2) food sources of saturated and polyunsaturated fatty acids, (3) indications for modifying the fat content of the diet, and (4) methods for modifying the diet, particularly the replacement of saturated fatty acids by polyunsaturated fatty acids.

S-XXII "Angina"

Michigan Division of Vocational Rehabilitation and Social Security Administration

This is a study of 1500 applicants who applied for Social Security disability benefits because of arteriosclerotic heart disease as manifested by angina.

The graphs represent the frequency with which medical reports contained historical, physical or laboratory evidence in support of these claims.

The authors are William Roemmich, Chief Medical Officer, Division of Disability Operations, Social Security Administration; Richard Hahn, M.D.; and F. M. Dugan, M.D.

S-XXIII "The Need is Great"

Holidays for Humanity

The overwhelming needs of the world's medically indigent people cries out for every form of assistance. How every physician can help, in even a little way, will be presented.

S-XXIV "AMA Educational Research Foundation Fund"

The Woman's Auxiliary of the American Medical Association

MSMS Annual Session Technical Exhibitors

Abbott Laboratories — Space No. 67
North Chicago, Ill.

Abbott Laboratories invites you to visit our exhibit. Our representatives will be happy to answer any questions you may have concerning our leading products and new developments.

Aloe Medical — Space No. 62
Division of Brunswick
St. Louis, Mo.

See 2nd Century, a fresh original concept in professional furniture combining major advances in function, durability and beauty. Unique Vyn-Steel finish is a permanent laminate of virtually indestructible vinyl to steel. Choose from a brilliant galaxy of eight striking color combinations. Other Aloe specialties and new items are displayed.

Ames Company, Inc. — Space No. 62
Elkhart, Ind.

HEMA-COMBISTIX will be shown and demonstrated at the Ames booth. HEMA-COMBISTIX is a new four-way, colorimetric, dip-and-read test for occult blood, protein, glucose, and pH in urine. Results for all four factors can be read within one minute. The Ames representatives will also be demonstrating several other simplified and standardized diagnostic tests.

Armour Pharmaceutical Company — Space No. 45
Chicago, Ill.

You are invited to attend the Armour Pharmaceutical Company exhibit which will feature: *Chymoral,* (Enzyme Tablets), a systemic anti-inflammatory enzyme tablet which reduces inflammation, swelling and pain; *Chymar Ointment,* (Proteolytic Enzymes with Neomycin and Hydrocortamate), effective topical preparation combining steroid, antibiotic and enzyme and *Listica,* (Hydroxyphenamate), conservative therapy for the relief of moderate and mild tension and anxiety.

Astra Pharmaceutical Products, Inc. — Space No. 100
Worcester, Mass.

Descriptive literature pertaining to preparations of XYLOCAINE® HCl (ASTRA) for infiltration, regional block, peridural, spinal, and topical anesthesia, XYLOCAINE OINTMENT, XYLOCAINE JELLY, and XYLOCAINE VISCOUS for topical application, as well as ASTRAFER® I.V. for iron deficiency states will be available at the ASTRA booth resided over by Edward W. Friedel.

Ayerst Laboratories — Space No. 43
Chicago, Ill.

Ayerst Laboratories extends an invitation to visit our exhibit located in Booth No. 43, where "Thiosulfil" and "Riopan" are featured. Our representatives will be pleased to discuss these or other Ayerst products with you.

Borcherdt Company — Space No. 77
Chicago, Ill.

Borcherdt's are featuring:
FERROMALT® TABLETS: A combination of Ferrous Sulfate with Maltsupex. Good clinical response without usual side effects of oral iron. Ferromalt Tablets are non-constipating, inexpensive, and well tolerated.
UROLITIA®: For chronic urinary tract infections in older patients. Quickly relieves burning urination.
MALTSUPEX® (Malt Soup Extract): Liquid, Powder, and Tablets. Dietary treatment for constipation in infants, children, and adults. Also very useful in treatment of intractable pruitus ani.
Register for information, samples and a useful pocket flashlight-magnifier to be mailed to your office.

Borden Company — Space No. 44
New York, N. Y.

Bristol Laboratories — Space No. 55
New York, N. Y.

Bristol Laboratories' exhibit features its five antibiotics: Kantrex (kanamycin sulfate) Injection, Syncillin (potassium phenethicillin), Staphcillin (sodium methicillin), Prostaphlin (sodium oxacillin) and Tetrex (tetracycline phosphate complex). Their wide range of activity is presented in an animated display, confirming the fact that there is a Bristol antibiotic for almost every bacterial infection.

Burroughs, Wellcome & Company, Inc. — Space No. 36
Tuckahoe, N. Y.

Please visit us for information on our products and the newest developments from the extensive research facilities of Burroughs Wellcome & Co. Of particular interest at this meeting are "Neosporin" and "Cortisporin" Creams for topical bacterial infections, "Mantadil" Cream for relief of itching, "Actifed" for respiratory congestion, and "Cardilate" for angina.

Carnation Company — Space No. 90
Los Angeles, Calif.

Carnation Company cordially invites you to visit Booth No. 90, where Medical Representatives will be pleased to welcome members and guests of the Michigan State Medical Society.
Recent literature and information regarding Carnation Evaporated, Carnation Instant Non-Fat and Carnalac are available and will be cheerfully discussed.

Ciba Pharmaceutical Products, Inc. — Space No. 20
Summit, N. J.

RITALIN® hydrochloride (methylphenidate hydrochloride CIBA) is a gentle stimulant and antidepressant which restores physical and mental activities to normal or near-normal levels. It has no adverse ef-

fect on blood, urine, liver or kidney function; it rarely affects appetite, blood pressure or pulse rate.

Coca-Cola Company — **Space Nos. 104-105**
Atlanta, Ga.

Ice-cold Coca-Cola served through the courtesy and cooperation of Coca-Cola Bottling Company of Grand Rapids, Michigan, and The Coca-Cola Company.

Coreco Research Corporation — **Space No. 98**
New York, N. Y.

The Coret Camera embodies the principle of electronic flash and constant automatic control of such factors as distance, aperture, field, and exposure. Now, for the first time, Coreco offers a completely automatic professional clinical camera purposely designed to achieve the ultimate in surface, intra-oral, and intra-tubular photography. Because of the simplicity of operation, even an inexperienced doctor or nurse can achieve consistently perfect color transparencies.

Cottrell-Clark, Inc. — **Space No. 91**
The Physicians Stationery Co.
Detroit, Mich.

Specializing in printing for Doctors and Hospitals since 1901.
Blank patient case history and physical examination forms, including various specialty case records, are stocked for quick delivery.
Manufacturers of the Manufile Loose-Leaf Binders. "The filing folder which keeps your patients records in book form."

Dictaphone Corporation — **Space No. 99**
Grand Rapids, Mich.

Thanks for visiting the Dictaphone Booth:
See the new Dictaphone Time-Master/7. It is like no other dictating instrument you have ever seen or heard about. Just seven pounds, seven ounces, it was styled by Dictaphone's experienced engineers. Also, the Travel-Master-Jr. partner at 5 pounds, and the all new Secretaire for your secretary.

Dietene Company — **Space No. 69**
Minneapolis, Minn.

Have you tasted Meritene? Meritene is the good-tasting *Protein*-vitamin-mineral Food Supplement prescribed to provide concentrated nutrition for patients with poor appetite or tolerance for ordinary food. Visit our booth and let us serve you a cool, refreshing Meritene Nourishment.
While there, review also our Dietene Reducing Plan, designed to get better cooperation from over-weight patients. The Dietene Plan provides optimum nutrition and maximum satiety without the use of drugs.
Meritene and Dietene are advertised only to the Medical Profession.

Dome Chemicals, Inc. — **Space No. 50**
New York, N. Y.

Dome Chemicals Incorporated, world leader in dermatologicals, will feature dermatological specialties that are of general interest to the members of the Michigan State Medical Society. Topical steroid products as CORT-DOME®, NEO-CORT-DOME®, DOMEFORM - HC®, LIDA - MANTLE - HC®, and COR-TAR-QUIN™, will be presented. The new sterile otic products such as Otic DOMEBORO®, Otic NEO-CORT-DOME® and Otic LIDAFORM™ will be presented.
Our representatives will be available to discuss with you several products recently released from the research laboratories of Dome Chemicals.

Eaton Laboratories, Inc. — **Space No. 103**
Div. of Norwich Pharmacal Co.
Norwich, N. Y.

Since 1939, Eaton Laboratories has pioneered in the development of the nitrofurans, many of which have been available, as legend drugs, to the profession. Basic and clinical research is continuing on these, as well as other classes of compounds.
In addition, Eaton Laboratories offers a variety of research and educational services for all phases of medicine. Our Medical Service Representatives at the Eaton Booth welcome the opportunity to furnish you with complete information covering these services and the nitrofurans.

Encyclopedia Americana — **Space No. 73**
Chicago, Ill.

Encyclopaedia Britannica — **Space No. 76**
Detroit, Mich.

Encyclopaedia Britannica welcomes delegates to the Michigan State Medical Society meeting and invites them to examine the great new edition of Britannica. Official delegates may now purchase this magnificent set at an exhibit offer only available at our convention exhibits. Visit Britannica Booth No. 76 for free descriptive literature.

Ferndale Surgical, Inc. — **Space No. 1**
Ferndale, Mich.

Fuller Pharmaceutical Co. — **Space No. 68**
Minneapolis, Minn.

THERAPADS, a unique preparation for daytime cleansing and therapy in acne vulgaris, will be featured at the Fuller exhibit. TUCKS, witch hazel wet dressing, and TRIAMEL OINTMENT and CREAM, for use in the management of post-partum perineal discomfort, diaper dermatitis, and perineal irritations, should be of particular interest to you.

Geigy Pharmaceuticals — **Space No. 56**
Yonkers, N. Y.

Geigy Pharmaceuticals cordially invites members and guests of the Association to visit our exhibit. The exhibit will feature Persantin Rx, a unique new therapeutic agent for the management of coronary and myocardial insufficiency. The distinctive pharmacologic and biochemical features of this compound are described in detail.

Gerber Products Company — **Space No. 57**
Fremont, Mich.

Gerber Flash Processed MODILAC . . . A complete formula for infants. Gently processed to conserve

nutritional values, it has true milk color and flavor. Modilac *is* milk adapted to the infant's physiologic requirements by the addition of a selected carbohydrate, replacement of butterfat with corn oil and supplementation with needed vitamins. Ask for complete information.

Great Books of the Western World **Space No. 78**
Oak Park, Mich.

The Syntopicon was developed by 75 scholars working together at the University of Chicago for eight years—at a cost of more than $1,000,000. Through an ingenious method of pointing the way, it actually makes finding information on any idea in the Great Books as easy as looking up a word in the dictionary.
Like a great teacher living in your home, the Syntopicon leads you to the volumes, chapters, pages, even to the very paragraphs that discuss any idea or topic of interest to you.

Hack Shoe Company **Space No. 66**
Detroit, Mich.

Let's talk shoes—prescription shoes and shoe prescriptions.
A representative listing of HACK SHOES for men, women and children will be on display and we offer our background of nearly 48 years of service to the profession.

H. J. Heinz Company **Space No. 22**
Pittsburgh, Pa.

HEINZ—"world's best-known"—Baby Foods are made by a new patented "super-quick" cooking process to assure maximum nutrition. Other important results—fresher flavor, more natural color and smoother texture.
New varieties are—Prune-Orange and Orange-Apricot Juice Drinks; Mixed and High Protein Cereal with Apples & Bananas; Strained and Junior Tuna with Noodles.

Holland-Rantos Company, Inc. **Space No. 70**
New York, N. Y.

H-R exhibit will feature and representatives will be pleased to discuss:
HYVA Gentian Violet Vaginal Tablets
A simple vaginal antimycotic treatment; Improved NYLMERATE Jelly & NYLMERATE Antiseptic Solution Concentrate for:
Trichomoniasis, Leukorrheas and Mixed Infections;
HOLLANDEX Skin Ointment for dermal disorders—diaper rash; chafing; skin dryness; prickly heat; sunburn;
KOROMEX® Vaginal Jelly for conception control when "Jelly Alone" is advised;
KORO-FLEX Contouring Diaphragms and Sets;
KOROMEX Diaphragms and Sets;
KOROMEX DOUCHE POWDER.

G. A. Ingram Company **Space Nos. 27-28**
Detroit, Mich

THE G. A. INGRAM COMPANY will display products manufactured by the following: Ames-American Optical-Bausch & Lomb- Becton & Dickinson-Burdick-Castle-Corbin-Farnsworth-Dallons-Hamilton-Johnson & Johnson-Liebel-Flarsheim- Minnesota Mining (3-M)-Ritter-Sklar-Taylor Instrument-Welch Allyn.

Johnson & Johnson **Space No. 33**
New Brunswick, N. J.

Johnson & Johnson will display the latest improvements in surgical dressings, as developed by the Johnson & Johnson Research Laboratories. Of special interest is SURGICEL Absorbable Hemostat, a major advance in the control of hemorrhage which does not depend upon the normal clotting mechanism. DERMICEL Surgical Tape, a newly-improved high strength special-purpose dressing tape for patients with unusual adhesive tape sensitivity, is an outstanding addition to the complete line of adhesive tape products. Other products, designed for your office, hospital or patient use, are also displayed. You will find well-informed representatives pleased to discuss these products or provide information on any other items made available by the world's largest manufacturer of surgical dressings and baby products.

Knoll Pharmaceutical Company **Space No. 79**
Orange, N. J.

DILAUDID Cough Syrup for "the cough that must be controlled"; also DILAUDID Ampules for pain that synthetic analgesics frequently fail to relieve. NICO-METRAZOL Elixir and Tablets have increased the scope of Oral METRAZOL Therapy, a field in which METRAZOL and VITA-METRAZOL are widely and successfully used in fatigue, geriatric and convalescent patients. QUADRINAL Suspension and Tablets for asthma. AKINETON Tablets and Ampules, the new agent for parkinsonism.

A. Kuhlman & Company **Space No. 109**
Detroit, Mich.

Lederle Laboratories **Space No. 59**
Pearl River, N. Y.

Members of the Michigan State Medical Society and their guests will be most cordially welcomed at the Lederle booth, which is No. 59. Our medical representatives, who have access to the world-wide Lederle research organization, are prepared to furnish information regarding Lederle products and your related medical questions.

Eli Lilly & Company **Space Nos. 24-25-26**
Indianapolis, Ind.

You are cordially invited to visit the Lilly Exhibit located in spaces 24-25-26. The Lilly sales representatives in attendance welcome your questions about our products, and offer you precise information about recent therapeutic developments of Lilly research.

J. B. Lippincott Company **Space No. 10**
Philadelphia, Pa.

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching are a continuation of more than 150 years of traditionally significant publishing.

Lloyd Brothers, Inc. **Space No. 84**
Cincinnati, Ohio

Welcome to the Lloyd Brothers exhibit. Our professionally trained sales representatives will be pleased to greet you and discuss the merits of our products in your practice.

Loma Linda Food Company **Space No. 31**
Arlington, Calif.

The Loma Linda Food Company, manufacturers of the tasty hypo-allergenic infant soy milk, Soyalac, will be pleased to show evidence of the nutritional adequacy of their product. The company is America's exclusive manufacturer of fibre-free soy milk. Qualified attendants will be pleased to explain why this milk is unusual in that it does not tend to raise infants' serum cholesterol. Uses of this milk for adult ulcer patients and in cholesterol-lowering diets will be discussed. Samples of this flavorful product will be served.

P. Lorillard Company **Space No. 89**
New York, N. Y.

You are cordially invited to visit the P. Lorillard exhibit.
There you will find a booklet on Lorillard's newest break-through in filtration research—the selective filtration of phenol from cigarette smoke. We feel sure you will find it interesting and informative. Lorillard is proud of this newest achievement and proud of the promise that you treat your taste kindly with Kent.
As a remembrance of your visit, Lorillard will be pleased to give you a table cigarette box with your signature in gold, filled with either Kent or Newport cigarettes. Newport is the choice of menthol cigarette smokers.
Please stop by and make your selection of this handsome souvenir.

Maico Hearing Service **Space No. 108**
Grand Rapids, Mich.

Maico features new more powerful and efficient hearing aid circuits in their new 1963 model hearing aids. New Mayfair Hearing Glasses fit all frames—received Merit Award Design—available in engraved design gold, silver, brown, black, or steel grey. Many designs in behind and all in the ear hearing aids. 90% of all hearing test equipment used by doctors, schools, government, etc. furnished by Maico Electronics, Inc.

Marion Laboratories, Inc. **Space No. 97**
Kansas City, Mo.

PAVABID is a unique continuous release Plateau Capsule of papaverine hydrochloride providing vascular relaxant activity for 24 hours with a convenient b.i.d. dosage.
PAVABID may be utilized effectively for the relief of cerebral and peripheral ischemia associated with vascular spasms, arrhythmias, and myocardial ischemia complicated by arrhythmias.

Marshall Erdman and Associates, Inc. **Space No. 65**
Madison, Wis.

Erdman Prefabricated Medical Buildings are the result of years of experience in the field of design, manufacturing and construction. No other company has had as extensive experience in this field. Over 900 doctors are now practicing in Erdman-built Medical Buildings.
Experienced Architects, Engineers and Construction Superintendents of the Erdman Company will design, manufacture and build your Medical Building from the land-planning stage until you open the door into your own office. We assume total responsibility for the entire job.

S. E. Massengill Company **Space No. 11**
Bristol, Tenn.

Best wishes from Massengill to the Michigan State Medical Society for a most successful meeting. Our representatives will welcome the opportunity to discuss products of interest to you. On display will be several Massengill specialty preparations, and literature will be available, should you desire it.

McNeil Laboratories, Inc. **Space No. 41**
Fort Washington, Pa.

Members of the Michigan State Medical Society are cordially invited to visit our Booth No. 41, Mr. Clell Shupert in charge. Products to be featured are: Butisol Sodium® butabarbital sodium, Clistin-D* and Tylenol® acetaminophen.
*Trademark

Mead Johnson Laboratories **Space No. 23**
Evansville, Ind.

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

Medical Arts Supply Company **Space No. 13**
Grand Rapids, Mich.

Medical Arts Supply Co. of Grand Rapids extends to you a hearty welcome to visit our booth where we will show the new equipment by Ritter and Hamilton Mfg. Co. newest examining room furniture plus a group of new instruments and diagnostic equipment.

Medical Protective Company **Space No. 96**
Fort Wayne, Ind.

With exceptional proficiency in defense, so essential to the Doctor's protection today, The Medical Protective Company offers unexcelled coverage in any claim or suit for damages based on professional services rendered or which should have been rendered. Its experience from the successful handling of 85,000 claims and suits during 64 years of Professional Protection Exclusively is unparalleled in the professional liability field.

Merck Sharp & Dohme **Space No. 46**
West Point, Pa.

The theme of the Merck Sharp & Dohme exhibit is "SERVICE TO MEDICINE." One phase features the details of the Merck Sharp & Dohme Postgraduate Program. Another feature includes information on teaching films for use by the profession and, also, lay films that can be utilized to portray the story of medicine to the lay public. The exhibit is concluded with a display of finger-tip files on selected Merck Sharp & Dohme products.

Wm. S. Merrell Company Space No. 71
Cincinnati, Ohio

Merrellmen always have an up-to-date status report on Merrell's significant prescription products. They will be happy to convey latest clinical reports to you in summary form when you visit the Merrell booth.

Meyer Laboratories Space No. 92
St. Clair Shores, Mich.

Meyer Laboratories will exhibit the following products at the MSMS Annual Session:
ATHEMOL: Each orange coated tablet contains magnesium 3, 7 dimethylxanthine oleate . . . 200 mg.
ATHEMOL-N: Each light green coated tablet contains: Magnesium 3, 7 dimethylxanthine oleate . . . 200 mg. and Magnesium Nicotinate . . . 100 mg.
DOCTATE-P: Each orange and white capsule contains Dioctyl Sodium Sulfosuccinate . . . 60 mg. and Oxyphenisatin Acetate . . . 2.5 mg.
Athemol and Athemol-N are indicated for the treatment of arteriosclerosis and atherosclerosis.
Doctate-P is an effective treatment for constipation. Besides being a fecal softener it contains a compound similar to prune extract which provides a mild laxative effect.

Michigan Medical Service Space No. 106
Detroit, Mich.

You are cordially invited to visit our booth to obtain current information regarding Michigan Medical Service (Blue Shield). Our representatives will be available to visit with you and answer any questions you may have with regard to your Blue Shield Plan.

MSMS Life, Health and Accident Insurance Program
East Lansing, Mich. Space No. 38

You are cordially invited to stop at Space No. 38 and discuss the MSMS Life, Health and Accident Insurance Program.
Representatives of the MSMS carriers will be present to answer questions concerning your MSMS group coverage.

Mullers Shoes, Inc. Space No. 81
Grand Rapids, Mich.

Attention Pediatricians: Our booth this year will have special emphasis on an expanded program of babies shoes. Many new types of normal and health footwear will be displayed.
We also invite all doctors interested in footgear and foot problems to view our complete program for all ages. Possibly you have an idea about shoes we can relay to our manufacturers.

Noble-Blackmer, Inc. Space No. 88
Jackson, Mich.

See the dynamic new concept to combat fatigue, the "Imperial" all formica modular cabinets—built-in function at your finger tips—wall hung and floor mounted pieces will be available for your inspection at Booth 88.
Remember, also, we are now serving the Kalamazoo area through our Drug Shop Division.

Hermien Nusbaum & Associates Space No. 95
Chicago, Ill.

Hermien Nusbaum and Associates invite you to see, discuss and register for samples and literature.
EVENFLO feeding equipment: new C-Thru clear plastic nurser; nipple covers whereby nipples may be sterilized in erect position.
DIAPREX and CARBAX: to prevent and correct skin irritations from diapers and other causes.
WEATHER-GUARD HEAT MASK: preheats air as it is breathed; recommended for adults and children for normal outdoor use, as well as for those with physical problems.

Ortho Pharmaceutical Corporation Space No. 30
Raritan, N. J.

Welcome to booth No. 30 where ORTHO is proud to present a complete line of medically accepted products for the control of conception. Featured will be ORTHO-NOVUM Tablets, the new oral product specifically designed for contraception. Representatives on hand will be happy to answer your questions on these and our other well-known products.

Pacific Medical Equipment Company Space No. 74
North Hollywood, Calif.

(Authorized Sales Outlet for Audio-Digest subscriptions—and equipment.)
Audio-Digest Foundation (a non-profit subsidiary of the California Medical Association) gives the busy physician a time-saving tour through the best of some 600 current medical journals, plus the highlights of scores of national meetings. Time-proven, but still unique—these medical tape-recorded services are now offered in seven series—General Practice, Surgery, Internal Medicine, Obstetrics & Gynecology, Anesthesiology and Ophthalmology.
Digest subscribers listen in their car, home or office. Carefully selected tape equipment for playing the Digests is offered at the convention by Pacific Medical Equipment Co.

Parke, Davis & Company Space Nos. 16-17
Detroit, Mich.

Medical service members of our staff will be in attendance at our booth to discuss important Parke-Davis specialties which will be on display.

Procter & Gamble Company Space Nos. 3-4
Cincinnati, Ohio

Ivory Soap (Procter & Gamble) offers a series of time-saving leaflet pads for doctors, each pad containing fifty identical tear-out sheets. These sheets, which may be given to patients, contain routine instructions covering general home care. There are also samples of other free, helpful material prepared especially for physicians.

Christyne W. Schwab, Director
Procter & Gamble Convention Program

Professional Management Space No. 47
Battle Creek, Mich.



Professional Management
A complete business service for the medical profession.
The trademark PM is the brand of distinction which identifies Professional Management offices affiliated with Black & Skaggs Associates, Inc. of Battle Creek, Michigan. It assures PM clients that the knowledge, experi-

ence and integrity of the oldest and largest such firm in the country are at their command.
Those in attendance at the MSMS Convention are cordially invited to stop at Booth No. 47 and meet the experienced PM Executives there.

Randolph Surgical Supply Company **Space No. 39**
Detroit, Mich.

Randolph Surgical Supply Company is happy to be exhibiting again this year, and will have many items of interest for the busy practitioner, and competent personnel to answer your questions.

R. J. Reynolds Tobacco Company **Space No. 60**
Winston-Salem, N. C.

Welcome to the R. J. Reynolds Tobacco Company Exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMEL, WINSTON Filter, Menthol Fresh SALEM, or CAVALIER King Size Cigarettes.

A. H. Robins Company, Inc. **Space No. 86**
Richmond, Va.

Welcome to the convention, Doctor, from the A. H. Robins Company.
We hope you can stop at our display for a moment. The representatives there will be happy to answer any questions you may have about our products and explain their advantages.
PRODUCTS FEATURED: Robinul and Pabalate.

Roche Laboratories **Space No. 49**
Nutley, N. J.

LIBRIUM (chlordiazepoxide)—a therapeutic agent for superior, safer, faster control of nervousness, anxiety, tension and other common emotional disturbances without the dulling effect or depressant action of the tranquilizers.

J. B. Roerig & Company **Space No. 83**
New York, N. Y.

J. B. Roerig and Company will welcome members of the medical profession at the Company's exhibit of leading specialty products. Representatives will be in attendance to answer any questions you may have. Roerig recently introduced a number of new products which representatives at the exhibit will describe and give information on the results of clinical reports.

Wm. H. Rorer, Inc. **Space No. 94**
Fort Washington, Pa.

ANANASE TABLETS—An oral fibrin-depolymerizing (Proteolytic) enzyme from vegetable origin.
MAALOX—A pleasant-tasting non-constipating antacid in Suspension, Tablets No. 1 and Tablets No. 2.
REPRESENTATIVES WILL GLADLY ANSWER YOUR QUESTIONS CONCERNING RORER PRODUCTS.

Ross Laboratories **Space No. 14**
Columbus, Ohio

Ross Laboratories, manufacturer of Similac, features SIMILAC WITH IRON, supplying 12 mg. of ferrous iron per quart of feeding at no additional cost. SIMILAC WITH IRON is designed for use with the premature from birth, and to provide prophylaxis against iron depletion starting about the fourth month or 14 pounds. Information about SIMILAC PM 60/40 and the newest Ross Booklets will be available.

Rupp & Bowman Company **Space No. 48**
Highland Park, Mich.

Welcome members and guests of MSMS! Stop in and see the latest in Diathermies, EKG "Push Button" Model—also electrically operated Hydraulic Table Dynapoise.

Sanborn Company **Space No. 102**
Waltham, Mass.

The new VISO-MONITOR and HEMODILUTER as well as the new SANBORN/FROMMER CELL COUNTER and ELECTROCARDIOGRAPHS of advanced design and function together with the latest models of other instruments for diagnostic use, will be displayed and demonstrated at the Sanborn Company Booth No. 102.
Demonstrations and/or data will also be available on Sanborn instruments for biophysical research—single and multi-channel recording systems, monitoring oscilloscopes and physiological transducers.
Qualified Sanborn representatives will be pleased to answer questions and assist you with technical problems.

Sandoz Pharmaceuticals **Space No. 35**
Hanover, N. J.

Sandoz Pharmaceuticals cordially invites you to visit our display at Booth No. 35, where we are featuring Sansert, Mellaril, Fiorinal and Fiorinal with codeine. Any of our representatives in attendance, will gladly answer questions about these and other Sandoz products.

W. B. Saunders Company **Space No. 29**
Philadelphia, Pa.

New Saunders' books of special clinical interest include: Cecil-Loeb: Textbook of Medicine, revised by Drs. Beeson and McDermott; Nadas: Pediatric Cardiology; Campbell: Urology; Hinshaw and Garland: Chest Diseases; and Aegerter and Kirkpatrick: Orthopedic Diseases.

Schering Corporation **Space No. 52**
Bloomfield, N. J.

Visit Schering's technical exhibit for the latest information on the following products: CELESTONE®, most active corticosteroid available; CHLOR-TRIMETON®, unsurpassed antihistamine; FULVICIN-U/F®, the new form of the oral antibiotic, Fulvicin, that halves the dosage requirement in most cases of ringworm; TRILAFON®, the tranquilizer and antiemetic of unexcelled efficacy.

Julius Schmid, Inc. **Space No. 87**
New York, N. Y.

An interesting and informative exhibit featuring IMMOLIN Vaginal Cream-Jel for use without a diaphragm, RAMSES Flexible Cushioned and BENDEX Diaphragms; RAMSES Vaginal Jelly; VAGISEC Liquid and VAGISEC PLUS Jelly and Suppositories for vaginal trichomoniasis therapy; and XXXX (FOUREX) Skin Condoms, RAMSES, SHEIK and SHEIK LUBRICATED Rubber Condoms for the control of trichomonal reinfection.

G. D. Searle & Company **Space No. 15**
Chicago, Ill.

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Siemed Incorporated **Space No. 101**
Hinsdale, Ill.

SIEMED INCORPORATED will display the complete line of SIEMENS medical equipment.
ULTRATHERM, ultra-shortwave therapy unit featuring conventional diathermy, deep-field therapy in the classical condenser field and microwave equivalent therapy with applicator MONODE and MINODE.
SONOSTAT, ultrasound generator.
CARDIOMAT, the most advanced electrocardiograph.

Smith Kline & French Laboratories **Space No. 34**
Philadelphia, Pa.

May we discuss the use of SK&F products in your specialty? Our Representatives are on duty to answer specific questions you may have. Also, information on SK&F Medical Films and other special services is available on request. Among the Spansule® capsule products featured will be Ornade® and Tuss-Ornade®.

Smith, Miller & Patch, Inc. **Space No. 75**
New York, N. Y.

Featured at our exhibit will be *LIPOFLAVONOID,* a new nutritional approach to the problem of vertigo and sensori-neural hearing loss associated with Meniere's disease; *VITRON-C,* a well-tolerated hematinic; *LIPOTRIAD,* a nutritional approach to therapy for the coronary-prone and diabetic patient; *VASOSULF,* a new topical ophthalmic solution containing an antibacterial and decongestant. Several other new ophthalmic preparations will also be presented.

E. R. Squibb & Sons **Space No. 63**
New York, N. Y.

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the Medical Profession in new products or improvements in products already marketed.
At Booth No. 63, we will be pleased to present up-to-date information on these advances for your consideration.

Standard Process Laboratories **Space No. 32**
Detroit, Mich.

The Endocardiograph is a precision instrument which amplifies and records heart sounds. The Endocardiograph will make apparent many points of diagnostic significance before they are sufficiently developed to be detected with the stethoscope. The Endocardiograph is a portable instrument. Graphs can be made in seconds without any special preparations.

Strasenburgh Laboratories **Space No. 42**
Div. of Wallace & Tiernan, Inc.
Rochester, N. Y.

"Strasionic" drug resinates are synthesized by exchanging drug ions for the cations of the resin. This is a reversible chemical reaction; and when the insoluble drug resinates ("Strasionic" drug resinates) enter the GI tract, the cations of GI tract are exchanged for drug ions of drug resinates. Since the cations of GI tract are in dynamic equilibrium (electrolytic balance), the rate of release is predictable and continuous. *THUS, WITH A SINGLE CAPSULE DOSE, PREDICTABLE THERAPEUTIC DRUG LEVELS ARE ESTABLISHED FOR UP TO 12 HOURS.*

The Stuart Company **Space No. 53**
Pasadena, Calif.

A cordial invitation is extended to all members and guests attending this meeting to visit the Stuart Company booth. Specially trained representatives will be in attendance to answer your questions on new products, developed in our modern laboratories, which have particular interest for the medical profession. Products featured are MYLANTA, STUART PRENATAL, PRENATAL-F, MULVIDREN-F and CARI-TAB.

Syntex Laboratories, Inc. **Space No. 61**
Palo Alto, Calif.

The Syntex exhibit will feature the successful topical steroid Synalar (fluocinolone acetonide), setting a new standard of success in the treatment of a wide range of dermatoses. Synalar is available in four forms:
Synalar Cream 0.025%, Synalar Ointment 0.025%—for initiation of therapy;
Synalar Cream 0.01%—for maintenance; and
Neo-Synalar—for treatment of infected dermatoses.
Synalar 0.025% and Neo-Synalar are available in 5 and 15 gm. tubes and Synalar 0.01% is available in a 45 gm. tube. Synalar Ointment is available in 15 gm. tubes only.

S. J. Tutag & Company **Space No. 80**
Detroit, Mich.

S. J. TUTAG & COMPANY WILL FEATURE THE CYDRIL FAMILY OF OBESITY PRODUCTS. OUR REPRESENTATIVES LOOK FORWARD TO DISCUSSING THE MERITS OF THESE PRODUCTS. AS WELL AS THE MANY OTHER ITEMS FOLLOWING WITHIN THE OBESITY THERAPEUTIC CLASSIFICATION.

U. S. Tobacco Company **Space No. 107**
New York, N. Y.

King Sano Cigarettes, Sano Plain, Sano All-Havana Cigars, and Sano Pipe Tobacco . . . all with less than 1% nicotine by weight will be sampled and displayed to the members of the medical profession. Sano meets the nicotine problem in the only effective way, by reducing the nicotine from the tobacco itself, before Sano tobacco products are made. Sano Cigarettes, Cigars, and Pipe Tobacco for good sense and good taste.

U. S. Vitamin & Pharmaceutical Corporation
New York, N. Y. **Space No. 2**

DBI—"broad-range" oral hypoglycemic agent. DBI, brand of phenformin (N^1-B-phenethylbiguanide HCl) is distinctly different in chemical structure and physiologic action from the oral hypoglycemic sulfonylureas. It effectively lowers blood sugar and eliminates glycosuria in mild, moderate and severe diabetes. DBI, in combination with insulin, improves regulation of "brittle" adult and juvenile diabetes. In juvenile diabetes, DBI often permits up to 50% reduction in insulin requirement. Also effective in the insulin-resistant, and in primary and secondary tolbutamide and chlorpropamide failures. Full details available.

The Upjohn Company **Space No. 12**
Kalamazoo, Mich.

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

Wallace Laboratories **Space No. 40**
Cranbury, N. J.

The representatives of Wallace Laboratories will be glad to discuss "Soma," a non-hormonal agent for the relief of chronic and traumatic pain and stiffness in muscles and joints, which is also useful in some neurological conditions. Side effects are limited to some sleepiness.

Warren-Teed Products Company **Space No. 93**
Columbus, Ohio

Ilopan—An injectable de-pantothenyl alcohol for the treatment and prevention of flatulent gastrointestinal distention.
Chymolase—An aqueous sterile solution of Chymotrypsin (5000 W-T units per cc and 50 mg. gelatin per cc) for relief of local inflammation and/or edema.

Westwood Pharmaceuticals **Space No. 58**
Buffalo, N. Y.

Westwood invites physicians to stop by their booth to discuss their unique dermatological products:
Fostex Cream, Lowila Emollient, Sebulex, Alpha-Keri, Fostex Cake, Lowila Cake, Fostril, Keri Lotion.
These products are particularly suitable for personal use by physicians and their families who may be plagued with dandruff, acne, dry and itchy skin, and sensitivities to soap. Register, so that we may send prescription units to your home.

White Laboratories **Space No. 21**
Kenilworth, N. J.

White Laboratories' Exhibit features Permitil Chronotab Tablets (brand of repeat-action tablets of fluphenazine dihydrochloride). Permitil Chronotab Tablets provide uninterrupted, day-long control of anxiety symptoms.

White & White Pharmacy **Space No. 51**
Grand Rapids, Mich.

Winthrop Laboratories, Inc. **Space No. 64**
New York, N. Y.

You are cordially invited to visit the Winthrop Booth No. 64 where representatives will be pleased to give you information on latest developments in the field of medicine.

W-T-S Pharmaceuticals **Space No. 54**
Div. of Wallace & Tiernan, Inc.
Rochester, N. Y.

DESENEX—Most widely prescribed fungicide used in the prevention and treatment of athlete's foot and other superficial fungous infections of the skin.
CALDESENE—Provides a lubricating and emollient film which is effective in the prevention or treatment of diaper rash and minor irritations.

PARENTAL ATTITUDES IN CHILD DEVELOPMENT

(Continued from Page 890)

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INFECTED ACNE AND OTHER PYODERMAS

(Continued from Page 892)

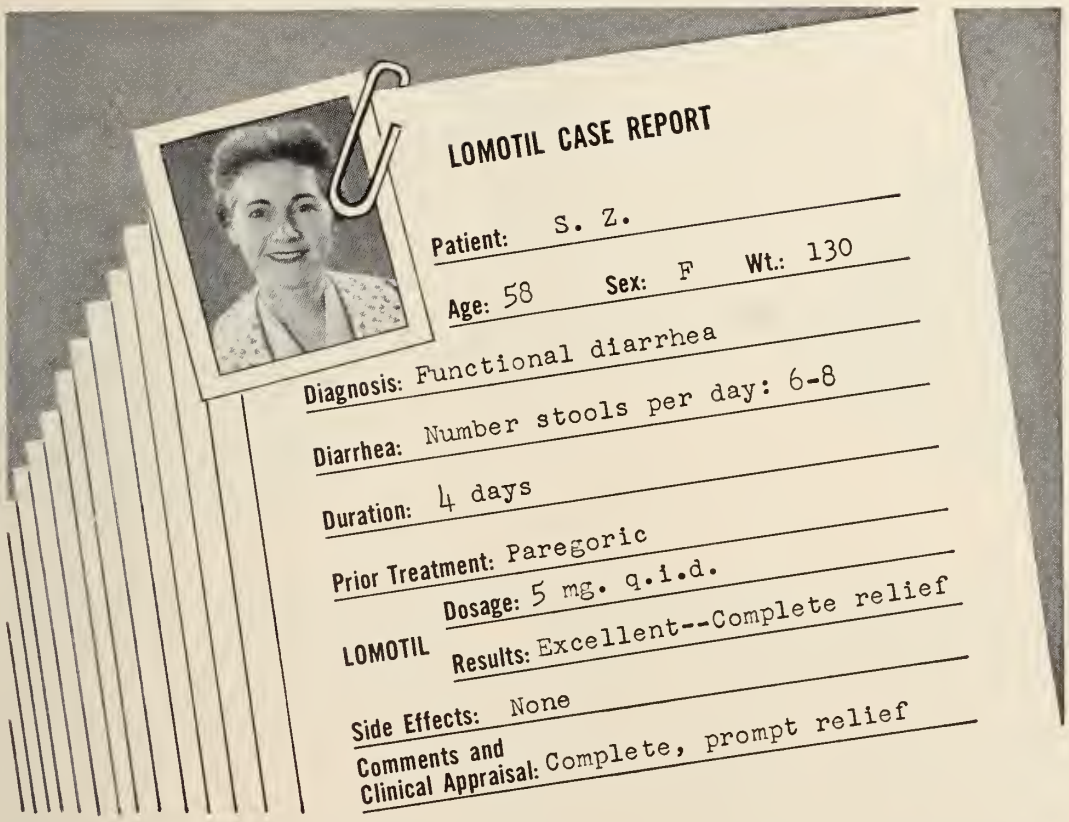
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To control diarrhea...promptly

prescribe LOMOTIL® promptly

Each tablet and each 5 cc. of liquid contains: 2.5 mg. of diphenoxylate hydrochloride (Warning: may be habit forming) and 0.025 mg. of atropine sulfate

The direct, well-localized activity of Lomotil relieves spasm and cramping and provides prompt symptomatic control of virtually all diarrheas.

Numerous investigators have remarked on the effectiveness of Lomotil in patients with diarrhea uncontrolled by other agents.

Weingarten and his associates[1] found it "an excellent drug . . . efficacious where other drugs have failed. . . ."

Hock[2] obtained "results superior to prior medications in 68.3 per cent of 41 patients."

Since Lomotil controls diarrhea so consistently, it is only rational to prescribe Lomotil *before* other agents have a chance to prove inadequate. To control diarrhea promptly, prescribe Lomotil promptly.

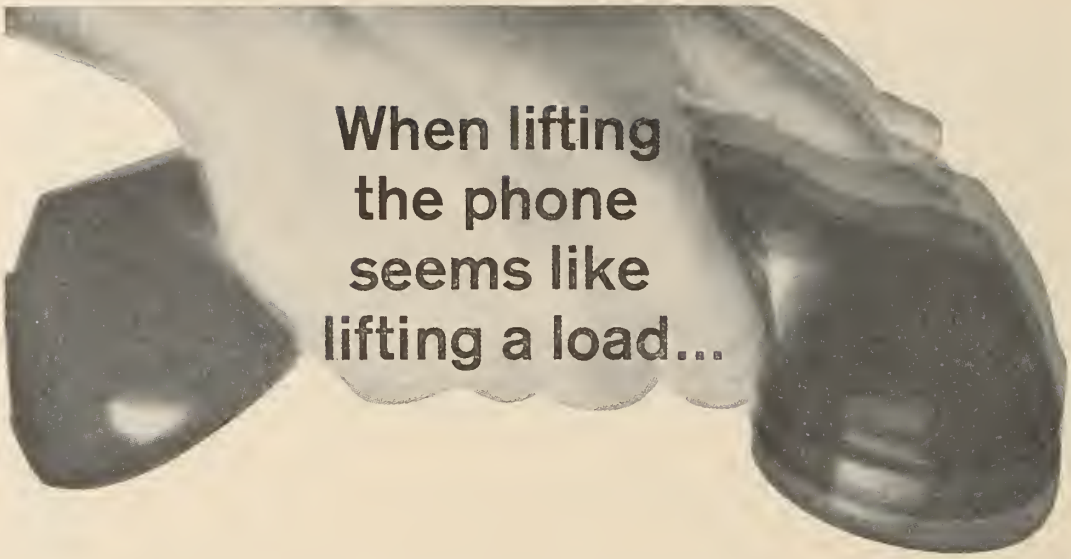
Lomotil is an exempt narcotic, its abuse liability being comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. Lomotil is brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of the latter is added to discourage deliberate overdosage.

1. Weingorten, B.; Weiss, J., and Simon, M.: A Clinicol Evoluotion of a New Antidiarrheol Agent, Amer. J. Gostroent. 35:628-633 (June) 1961. 2. Hock, C. W.: Relief of Diorrhea with Diphenoxylote Hydrochloride (Lomotil), J. Med. Ass. Georgio 50:485-488 (Oct.) 1961.

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Research in the Service of Medicine

Say you saw it in the Journal of the Michigan State Medical Society



in chronic bronchitis and emphysema

ISUPREL® BRAND OF ISOPROTERENOL
hydrochloride hydrochloride

MISTOMETER® Q.I.D.

ISUPREL (isoproterenol/Winthrop) "...can increase breathing efficiency in pulmonary emphysema."[1] The patient with chronic obstructive pulmonary disease "...should use the bronchodilator four times daily whether or not he experiences episodes of bronchospasm."[2]

Use of the Mistometer eases breathing by relaxing bronchospasm, and aiding productive cough. "Of the aerosol bronchodilators, ISUPREL (isoproterenol/Winthrop) seems to be the best...."[3] Conscientious use q.i.d. improves vital capacity and exercise tolerance.

The Mistometer brings new efficacy and convenience—enables patients to maintain treatment wherever they are.

With use of ISUPREL (isoproterenol/Winthrop), occasionally tachycardia, palpitation, nervousness, nausea and vomiting or headache may occur, especially with excessive dosage. Adjust dosage carefully in patients with hyperthyroidism, acute coronary disease, cardiac asthma or limited cardiac reserve, and in persons sensitive to sympathomimetic amines.

Caution: Epinephrine should not be administered with ISUPREL (isoproterenol/Winthrop) as both drugs are direct cardiac stimulants and their combined effects may induce serious arrhythmia. If desired they may, however, be alternated, provided an interval of at least four hours has elapsed.

Dosage: Two inhalations at least one minute apart four times daily, regularly. Inhalations may be taken more often if indicated.

Available as ISUPREL HCl (isoproterenol HCl/Winthrop) Mistometer—single unit combining plastic nebulizer and ISUPREL (isoproterenol/Winthrop) solution 1:400—or 0.25 per cent w/w (=2.8 mg. per ml.), and includes alcohol, 33 per cent; bottles of 15 ml.



1. Reeves, J. E.: *M. Times* 90:512, May, 1962. 2. Williams, M. H., Jr.: *M. Sc.* 11: 433, March 19, 1962. 3. Peckenschneider, L. E.: *J. Kansas M. Soc.* 56:486, Sept., 1955.

Winthrop Laboratories, New York 18, N.Y.

Winthrop

Medical Quackery In Michigan

(Excerpts from address by GEORGE FOWLER, *Assistant to the Director, U. S. Food and Drug Administration, Detroit, given at the annual meeting of the Michigan Health Council, May 1963)*

No actual figures about quackery are available to show its extent, what it costs the nation in money, injuries, or lives. What we have at best are only educated guesses from those most familiar with the problem. One guess is that the total bill exceeds one billion dollars a year.

Of this, so-called vitamin and health food quackery amounts to possibly a half billion. On the basis of a survey, the Arthritis Foundation demonstrated that $250 million is wasted annually on fake arthritis treatments. The costs of ineffective drugs and devices for reducing must exceed $100 million. The total figure might be well over one billion dollars.

* * *

IT IS DIFFICULT TO relate this to the State of Michigan for again there are no accurate figures. Although the quacks may have a predilection for milder climes, certainly no area in the U. S. is free of quackery. Prorated on a population basis, the total bill for quackery in Michigan would exceed $45 million.

That Michigan is not free of quackery is clearly demonstrated by legal actions taken in Michigan by the Federal Food and Drug Administration. These include actions taken against:

(a) Device quackery
(b) Nutritional quackery
(c) Drug quackery

* * *

THERE IS NO PAT ANSWER as to a remedy for quackery in Michigan or anywhere else. Where there are laws, they must be strictly enforced. Doctors must realize that in a sense they are the victims of quackery since in the long run it makes their job more difficult. To convict a quack, prosecutors must have medical assistance —medical testimony—and doctors are in a better position than most to detect and report quackery.

Finally, all people in the field have an obligation to educate the citizenry so they will be aware of and avoid quackery.

* * *

New U-M Department Heads

Two new department heads have been announced at the University of Michigan Medical School.

William S. Smith, M.D., director of the division of orthopaedic surgery at Ohio State University, will become professor of surgery



HAY FEVER • ASTHMA

How to restore your patient's allergic balance the "classic" way . . . use specific desensitization for

LASTING IMMUNITY

For General Medicine, Internal Medicine, Eye, Ear, Nose, Throat, Pediatrics and Dermatology



ALLERGIC BALANCE is determined by skin testing. Diagnostic Sets $2 and up. Skin test your patients quickly and safely in your own office.



LASTING IMMUNITY is achieved by desensitization, economically, with IMMUNOREX, the "classic" treatment (contains only the specific irritants to which your patient reacts).

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and head of the orthopaedic surgery section October 1. He will succeed Carl E. Badgley, M.D., who began his retirement furlough July 1 after being a member of the U-M Medical School faculty since 1920. Dr. Smith received his M.D. from the U-M Medical School in 1943, served briefly as an instructor at the U-M Medical School in 1950 before going into private practice in Baltimore, Maryland, and Columbus, Ohio. Dr. Smith joined the faculty of Ohio State's College of Medicine in 1952.

J. Robert Willson, M.D., who took his post-graduate training under Norman F. Miller, M.D., chairman of the University of Michigan Medical School's department of obstetrics and gynecology, will succeed Dr. Miller in that capacity on January 1. Dr. Willson, 50, is now professor and chairman of the department of obstetrics and gynecology at Temple University School of Medicine. Dr. Willson was graduated from the U-M Medical School in 1937, served the U-M Medical School faculty from 1941 to 1942, then went to the University of Chicago in 1942 and then to Temple University in 1942.

Dr. Miller will begin his retirement furlough January 1, 1964, after 42 years of service on the U-M Medical School faculty, 32 of them as professor and chairman of the department of obstetrics and gynecology.

U-M Postgraduate Courses To Begin in September

The University of Michigan calendar of postgraduate courses is full for 1963-64 and several of them will begin in September and October with the majority of them beginning early in 1964. Detailed information may be obtained from John M. Sheldon, M.D., Department of Postgraduate Medicine, University Hospital, Ann Arbor.

Listed for the fall are:

Clinical Internal Medicine, an intermittent course on Thursday afternoons, September 12 to January 23.

Electrocardiography and Heart Disease, intermittent course, Tuesday evenings, September 24-January 14.

Cardiac Resuscitation, continuous course, beginning October 7.

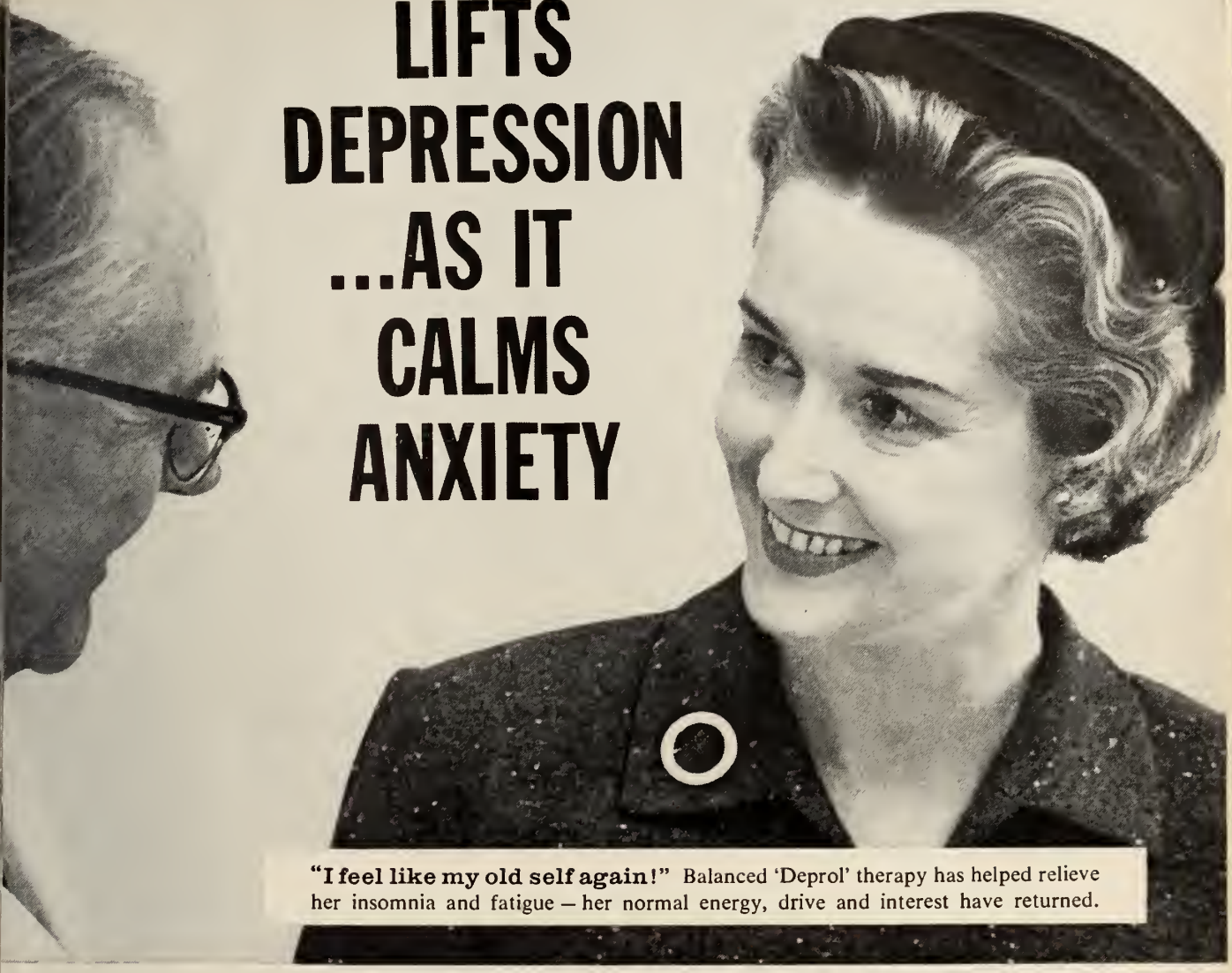
Basic Sciences and Their Clinical Correlation and Application—Pathology, continuous course, September 30-December 11.

Basic Sciences and Their Clinical Correlation and Application—Microbiology and Immunology, December 12-20.

Twenty-seven other courses are listed for 1964.

(Turn to Page 918)

LIFTS DEPRESSION ...AS IT CALMS ANXIETY



"I feel like my old self again!" Balanced 'Deprol' therapy has helped relieve her insomnia and fatigue – her normal energy, drive and interest have returned.

Brightens mood...relaxes tension

Energizers may stimulate the depressed patient, but they often aggravate anxiety and insomnia. Tranquilizers may help the anxious patient, but they often deepen depression. 'Deprol' avoids these "seesaw" effects; it relieves both anxiety and depression. Moreover, it does not cause liver damage, psychotic reactions or changes in sexual function.

Slight drowsiness and, rarely, allergic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. Meprobamate may increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. Withdraw gradually after prolonged use at high dosage.

Usual Dosage: 1 tablet q.i.d. May be increased gradually, as needed, to 3 tablets q.i.d.; with establishment of relief, may be reduced gradually to maintenance levels.

▲Deprol▲®
meprobamate 400 mg.
+ benactyzine 1 mg.

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CD-9237

Blue Cross-Blue Shield Receive 31,000 Enrollments In MMS-MHS Non-Group Drive

Blue Cross-Blue Shield during the 1963 Non-Group and Senior Citizen enrollment drive reached a record number of more than 31,000 applications.

The Non-Group campaign, the first since 1961, opened July 15 and closed July 31 with more than 21,000 applications for the under-65 Non-Group coverage, and more than 10,000 for the Senior Citizen contract.

Enrollment officials expect that approximately 26,000 applicants will be covered by the effective date, August 20, 1963.

During the 1961 Non-Group and Senior Citizen enrollment drive, a total of 21,445 applications were received and 18,023 actually enrolled, 10,725 in Non-Group and 7,298 in Senior Citizen. Approximately 80 per cent of those who file applications with Blue Cross-Blue Shield during these drives finally become subscribers.

Not counting the results of the 1963 campaign, the Blues currently have 69,800 enrolled in Non-Group and 16,000 in the Senior Citizen plan.

U-M Invites Alumni Back for October 17-19

Beginning this fall, the University of Michigan Medical Center will shift to a new pattern for its alumni conferences. The former "triennial" reunions will be replaced with a yearly alumni reunion. This year, it will be held October 17-18-19.

Special activities are being planned for October 17 by many of the classes which will be celebrating their fifth anniversary, tenth anniversary, etc. This will involve such classes as 1959, 1953, 1948, 1943, 1938, 1933, 1928, 1923, 1918, and 1913.

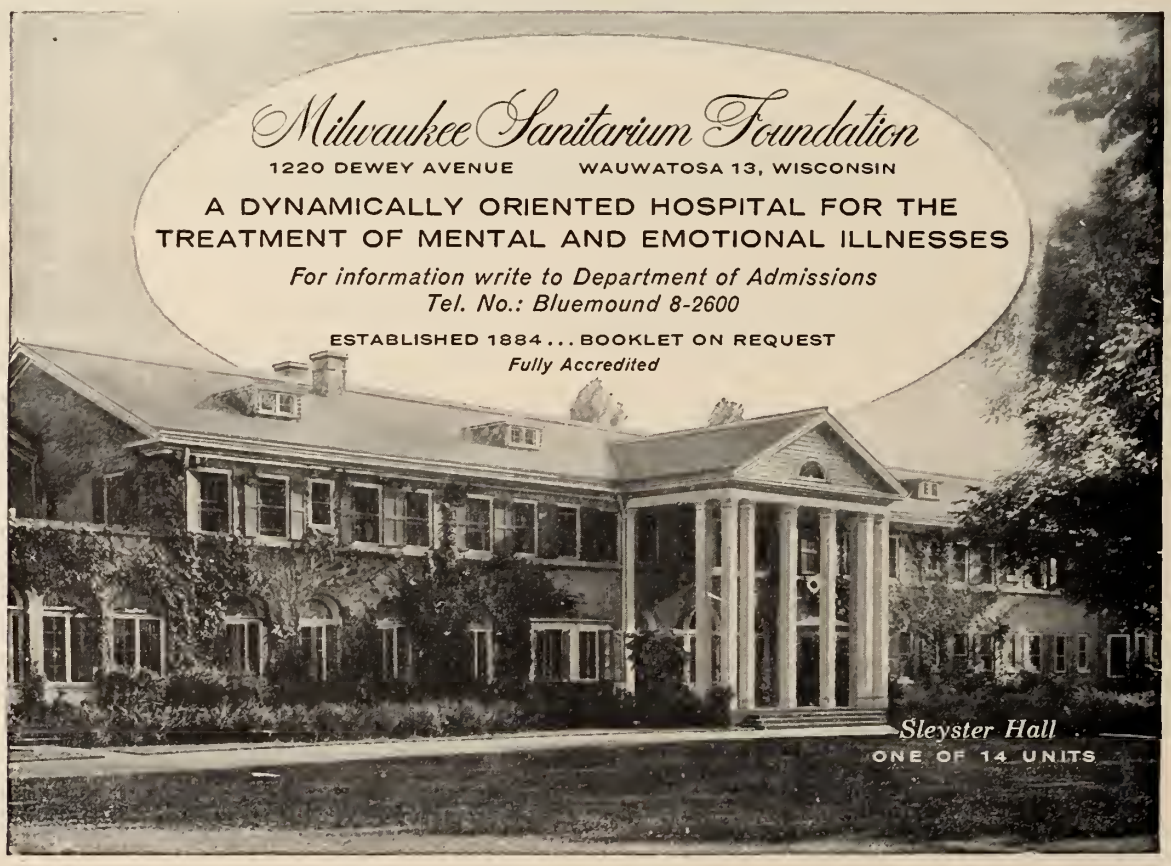
The conference program will begin on October 18 with scientific sessions in the morning and afternoon, along with a luncheon and banquet-dance in the evening.

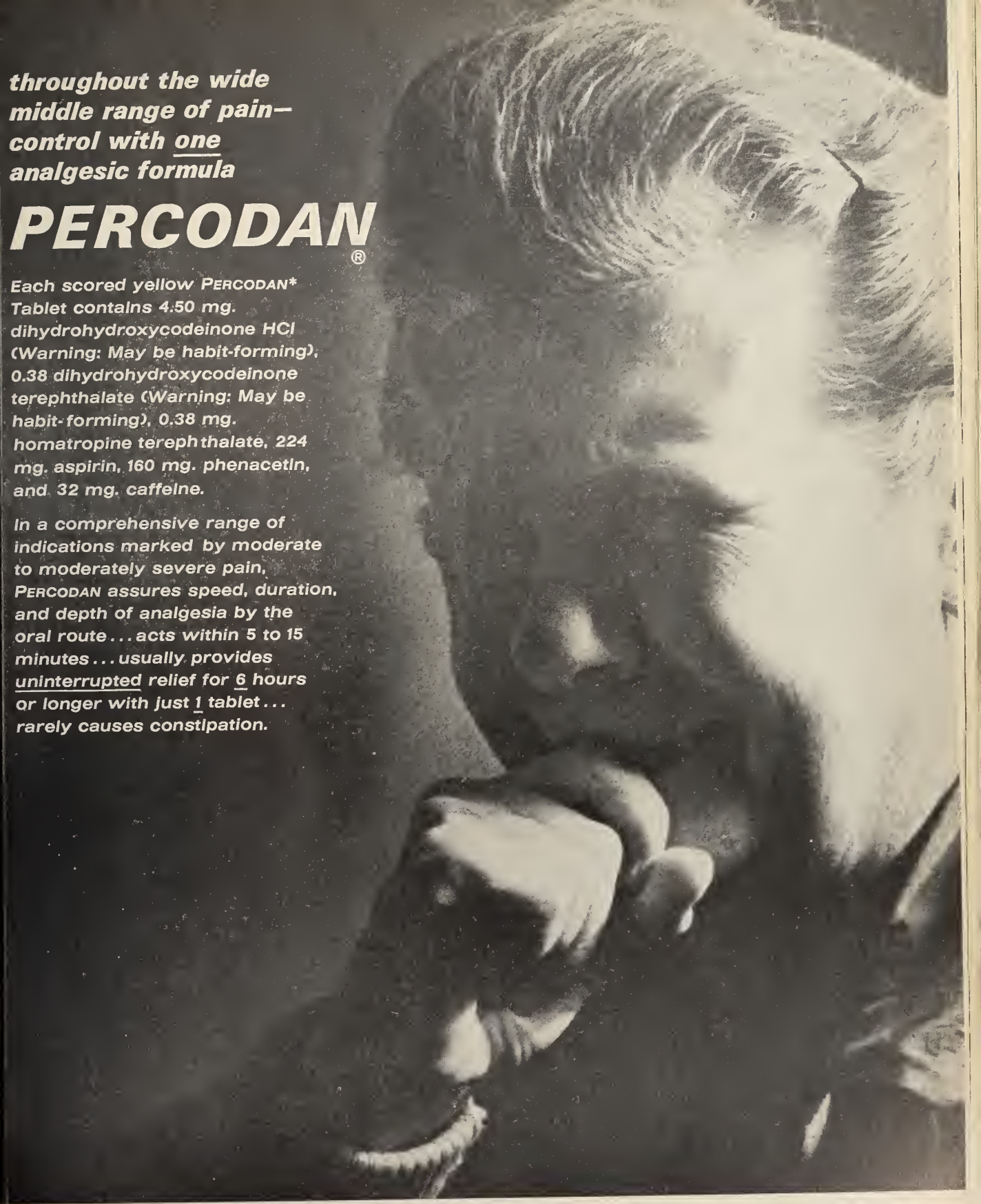
A big tent will be erected on the Ann Arbor High School grounds Saturday, October 19, for an alumni picnic before the Michigan-Purdue football game.

Applications Due Soon

The deadline for those seeking fellowships and investigatorships from the Michigan Heart Association to support research efforts beginning July 1, 1964, is

(Continued on Page 920)





throughout the wide middle range of pain—control with one analgesic formula

PERCODAN®

Each scored yellow PERCODAN* *Tablet contains 4.50 mg. dihydrohydroxycodeinone HCl (Warning: May be habit-forming), 0.38 dihydrohydroxycodeinone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.*

In a comprehensive range of indications marked by moderate to moderately severe pain, PERCODAN *assures speed, duration, and depth of analgesia by the oral route... acts within 5 to 15 minutes... usually provides uninterrupted relief for 6 hours or longer with just 1 tablet... rarely causes constipation.*

Average Adult Dose—1 tablet every 6 hours. **Side Effects and Contraindications**—Although generally well tolerated, PERCODAN may cause nausea, emesis, or constipation in some patients. PERCODAN should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. **Also available:** PERCODAN®-DEMI, containing the complete PERCODAN formula but with only half the amount of salts of dihydrohydroxycodeinone and homatropine. Both products are on oral Rx in all states where laws permit. Narcotic order required. **Literature on request.**

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reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem. KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untoward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.



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parenteral hemostat

Each cc contains: 5 mg. oxalic acid, 2.5 mg. malonic acid, phenol 0.25%; sodium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart on request.

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920

Applications Due Soon

(Continued from Page 918)

September 15. The grants-in-aid applications must be received by November 1. Further information may be obtained from the Director for Research, American Heart Association, 44 E. 23rd Street, New York 10.

Transfer Occupational Therapy To Wayne Medical School

Wayne State University has transferred its department of occupational therapy from the College of Liberal Arts to the College of Medicine. Dean Martin Stearns, of the College of Liberal Arts, recommended it changed because, "the bulk of the work by occupational therapists is performed in hospitals and medically oriented programs. We felt the program would be strengthened by moving it to the medical college."

Approximately 65 students are affected by the change. Barbara Jewett will continue as head of the department, which is housed in the Rehabilitation Institute, near Harper Hospital.

WSU Enlarges Class By 25 Students

Twenty-five additional qualified applicants will be admitted to Wayne State University's College of Medicine in September as a result of action by the Michigan State Legislature adding $500,000 to the University's operating budget for the coming fiscal year.

Dr. Gordon H. Scott, vice president for medical college development, explained: "Because adequate appropriations could not be made available to the College in the past two years, the entering class had to be cut back from 125 to 100. In fact funds have been inadequate to obtain the clinical faculty for this number. Last year and this year we have had to 'farm out' the extra 15 students in the senior year to hospitals and volunteer teachers. This charity approach could not continue and was not a satisfactory way to teach medicine."

Medical Assistants Confer

Michigan Medical Service is holding a state-wide series of 24 educational seminars for medical assistants. The first seminar was held June 5 at Ann Arbor; the series will close November 21 in Oakland County.

Miss Helen M. Schick, educational coordinator of Blue Shield, will conduct the all-day meeting to help medical assistants to better interpret Blue Shield contracts and to fill out the necessary forms.

blood, milk and Maalox®

(magnesium-aluminum hydroxide gel)

Practically standard treatment, now, for perforated ulcer. Why is Maalox included? Antacid therapy *must* continue long after the wound has healed, and patients started on Maalox tend to stay on Maalox. It tastes good; it's effective and will not cause constipation—three important reasons for Maalox over the long haul. Some physicians, we are told, order Maalox routinely for hospital patients on drugs which could irritate. They feel it reduces the likelihood of gastric discomfort. Supplied: Suspension; Tablets No. 1; Tablets No. 2. (Each Maalox No. 1 Tablet is equivalent to 1 teaspoonful and each Maalox No. 2 Tablet is equivalent to 2 teaspoonfuls of Suspension.)



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Electrocardiography

The answer may be "yes" for several good reasons. A truly up-to-date electrocardiograph is an integral part of the modern office practice. Taking an ECG in the office is a simple, routine procedure that your nurse or technician can handle.

Tax savings due to depreciation write-offs and a substantial trade-in value of your old ECG can make the purchase of a new Burdick EK-III Electrocardiograph far more attractive financially than you ever thought possible. Trading-up now will save you both time and money — and give you accurate, high-fidelity records. The EK-III also gives you a top-loading paper drive, simplified controls, compact design, two speeds, a new tubular flat-writing stylus, no paper curl.

More than 20,000 users of Burdick cardiographs can't be wrong. Burdick has taken the trouble out of ECG's to help you keep your office appointments on schedule. Let your Burdick dealer bring you up to date, at your convenience and without obligation — or you can write us directly.

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Michigan Medical Meetings

Michigan State Medical Society Annual Session, September 22-27, Civic Auditorium—Pantlind Hotel, Grand Rapids (House of Delegates, September 22-24; Scientific Session, September 25-27).

Michigan Medical Service Annual Meeting, Grand Rapids, September 24.

Woman's Auxiliary of Michigan State Medical Society Annual Meeting, September 24-27, Pantlind Hotel, Grand Rapids.

Michigan State Medical Assistants Society Annual Meeting September 25, 26 at Morton House, Grand Rapids.

Midwest Regional Group of Medical Library Association, October 3-5, Bronson Hospital, Kalamazoo.

Bronson Methodist Hospital Annual Clinical Conference, October 16, Kalamazoo.

Alumni Conference Michigan Medical Center, October 17-18-19, Ann Arbor.

Hospital Section of Michigan Library Association, October 18, Bancroft Hotel, Saginaw.

South Central Michigan Clinic Day, October 24, Battle Creek.

Michigan Tuberculosis and Respiratory Disease Association and Michigan Thoracic Society, Annual Meeting, October 24, Kellogg Center, Michigan State University.

American College of Obstetricians and Gynecologists, District V, October 24-25-26, Statler Hilton Hotel, Detroit.

Genesee County Medical Society Diabetes Day, November 6.

Michigan State Medical Assistants Society President's Workshop, November 10, Mt. Clemens.

Michigan Academy of General Practice, 17th Annual Fall Postgraduate Clinic, November 13-14, Sheraton-Cadillac Hotel, Detroit.

American College of Physicians' First Sectional Meeting, November 21-22-23, Sheraton-Cadillac Hotel, Detroit.

Canadian-American Medical and Dental Ski Association, February 17-18-19, 1964, Harbor Highlands, Harbor Springs.

* * *

Invitation from U-M Alumni Society

The University of Michigan Medical Center Alumni Society will welcome alumni and friends to its hospitality suite in the Pantlind Hotel during the Michigan State Medical Society meeting, September 22-27 in Grand Rapids.

"Operation Hometown" Join Now—Act Now

"Operation Hometown" is a nationwide intensive and continuing program for each county medical society to help offset the mounting pressure for King-Anderson legislation in the 88th Congress.

This year could see the beginning of the end of America's high health care standards and the freedom of the medical profession—unless physicians and other community leaders take the initiative now.

The medical profession's voice, to be effectively heard in Congress, must be amplified with that of the public in widespread protest. This campaign is designed to reach every segment of the American public through every possible medium, to stimulate every voter to let his Congressman know that medicare is really a costly concoction of bureaucracy, bad medicine, and an unbalanced budget.

The facts on this issue must be made known, and "Operation Hometown" provides the tools and techniques for your county medical society to present them to your fellow citizens.

Here is how "Operation Hometown" works:

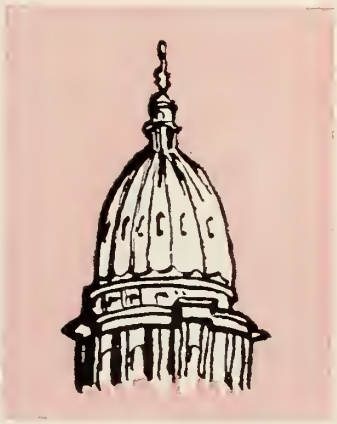
- Operation Hometown is planned by and for medical doctors to be carried out at the county society level. A kit contains portfolios with helpful suggestions and material for seven segments of activity. The division of activities is as follows: (a) County Campaign Chairman, (b) Speaker's Bureau, (c) Enlisting Allies, (d) Newspapers, Radio and TV, (e) Letter Writing, (f) Material Distribution, and (g) Congressional Contacts.

- The AMA kit was distributed to each County Medical Society President by MSMS in June.

- The President appoints a General Chairman whose responsibility it is to coordinate the work of the campaign through six chairman each of whom is responsible for one segment.

- The physicians of the County Medical Society enlist their services in those phases of the campaign best suited to their abilities.

- Each County Medical Society is assigned a Michigan State Medical Society Field Secretary to assist it in its planning and implementation of the program.



Observes Degrading Efforts

Some public officials have become more concerned about protecting the people against drugs and physicians than against disease, Austin Smith, M.D., president of the Pharmaceutical Manufacturers Association, declared in a speech recently to the Connecticut Medical Society.

As a consequence, Doctor Smith noted that the physician, "long hailed as a healer, personal confidante, and community leader," is now regarded with suspicion and distrust.

The drug manufacturer, who has heretofore been praised as "the beneficent source of life-saving health-giving miracles," now stands accused of "wilfully dispensing dangerous and worthless medicine and making unconscionable profits at the expense of the ill and the elderly," Doctor Smith added.



"...emphatic DIETARY REFORM with LITTLE C.N.S. stimulation..."

CYDRIL*

*Brond of (*l*-isomer) 1-phenyl-2 ominopropone succinote

TWO CONVENIENT DOSAGE FORMS...

Each CYDRIL **TABLET** contains:
(*l*-isomer) 1-phenyl-2 aminopropane succinate 7 mg.

Each CYDRIL **GRANUCAP**† contains:
(*l*-isomer) 1-phenyl-2 aminopropane succinate 21 mg.
(Releasing the drug over a 6-10 hour period.)

AVAILABLE: **TABLETS** — Bottles of 100, 500, 1000
GRANUCAPS† — Bottles of 100, 1000

Request clinicol samples and literoture on your letterheod.

†GRANUCAPS — T.M. Reg. U. S. Pat. Off.

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A facility designed to rehabilitate or to aid the addict in arresting his addiction.

Brighton Hospital meets the standards established by the Michigan State Board of Alcoholism and is recommended by that Board.

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One block south of I-96 at Kensington Road exit
Four miles east of U.S. 23
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Brief and to the Point

HONORED BY AMA—The Hektoen Gold Medal Award was bestowed at the AMA Scientific Awards Banquet June 19, in Atlantic City on Drs. Harold M. Frost, Elias D. Sedlin, and Max Klein, of the Henry Ford Hospital in Detroit, for their exhibit on the "Osteodynamics and the Osteoporoses."

* * *

CITED—James H. Fyvie, M.D., Manistique, was presented a gift from the B.P.O.E. Elks at a recent recognition banquet in Manistique. Tributes were paid by spokesmen for the Selective Service Board, the Manistique High School and the Schoolcraft Memorial Hospital. More than 150 attended the community tribute.

* * *

PHYSICIAN-OF-THE-YEAR—Lloyd J. Paul, M.D., was recently named "Physician-of-the-Year" by the interns of Sinai Hospital, Detroit, at the Alumni Day Program. Doctor Paul was cited as "the member of the voluntary attending staff who contributed the most to intern education" during the past year. Several other awards were made—Maurice Frankel, M.D., was selected as "the outstanding intern for 1962-63;" and the Harry E. August Award for "outstanding performance during his year in psychiatry" was presented to Donald Silver, M.D., Detroit.

* * *

HONORED—Before leaving Michigan, Capt. Owen L. Felton, M.D., was cited by the Air Defense Command for outstanding work performed at the Kincheloe Air Force Base near Sault Ste. Marie. Doctor Felton was in charge of the medical work at Kincheloe from October 1961 to May 1963, before being transferred to an Air Force residency in pathology at the Dusta Madison General Hospital at Madison, Wisconsin.

* * *

ON PROGRAM—The program for the Cleveland Clinic postgraduate courses October 2-3 in "Gastroenterology on Disease of the Small Intestine" will include H. Marvin Pollard, M.D., of Ann Arbor, as speaker.

* * *

WINS AWARD—Gerald Alexander Ahronheim, Jackson, a first-year student at the University of Michigan Medical School, has been awarded a $600 Student Scholarship by the Allergy Foundation of America. Mr. Ahronheim will carry out proposed research in "Pressure-Flow Measurements to Determine Nasal Air Resistance."



The most significant advance in analgesics since the isolation of morphine in 1805

Remarkable effectiveness and greater freedom from side reactions in the widest range of clinical applications

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clinically tested for 5 years/evaluated in 120 U. S. hospitals/over a quarter of a million doses given/more than 25,000 patients treated

SUPPLIED:

Vials: 10 cc., singly and in boxes of three.
Ampuls: 1 cc. and 2 cc., in boxes of 12 and 100.
(Each cc. of NUMORPHAN* contains 1.5 mg. oxymorphone as the hydrochloride.)
Suppositories: 2 mg. and 5 mg., in boxes of 6.

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JAMES LOVELL, of Dexter, has completed his freshman year at the University of Michigan Medical School with lots of help (?) from two sets of twins. James and his wife are shown reading to Jamie and Julie, the first set, on his lap, and Pam and Tony looking on. What's his field of interest in medicine? That's simple: Obstetrics.

* * *

SPEAKER CHOSEN—K. R. Porter, Ph., professor of biology at Harvard, has been selected to present the 12th Annual Edsel B. Ford Memorial Lecture at the Henry Ford Hospital Auditorium at 7 p.m., October 15. Professor Porter has worked and published extensively in developmental and cellular biology.

* * *

PAPERS REQUESTED—The Michigan Heart Association, busy planning the 1964 Heart Day set for February 22 at the Statler-Hilton Hotel, Detroit, requests Michigan physicians and researchers interested in presenting short papers to submit abstracts. New projects and reports—with emphasis on clinical subjects—are invited. Mail abstracts to the Medical Director, Michigan Heart Association, 13100 Puritan, Detroit 27.

* * *

JOINS U-M—Calvin Woodruff, M.D., chairman of the pediatrics department at the American University in Beirut, recently joined the University of Michigan in charge of an expanded public health nutrition program in the School of Public Health.

* * *

APPOINTED—David L. Steinem, M.D., is serving as the director of the adult division of the Lansing Area Child Guidance and Mental Health Centers. A graduate of the McGill medical school, he formerly was on the psychiatric staffs at Apple Creek State Hospital in Ohio and the Dayton Children's Psychiatric Hospital. William H. Kelly, M.D., assistant director of the Michigan Department of Mental Health, had been serving as acting director for the past year.

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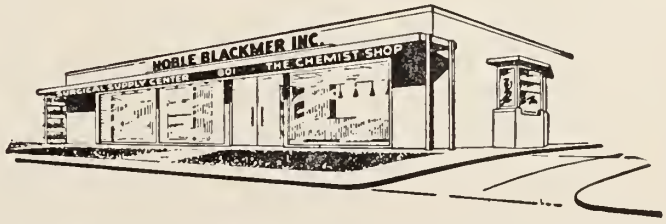
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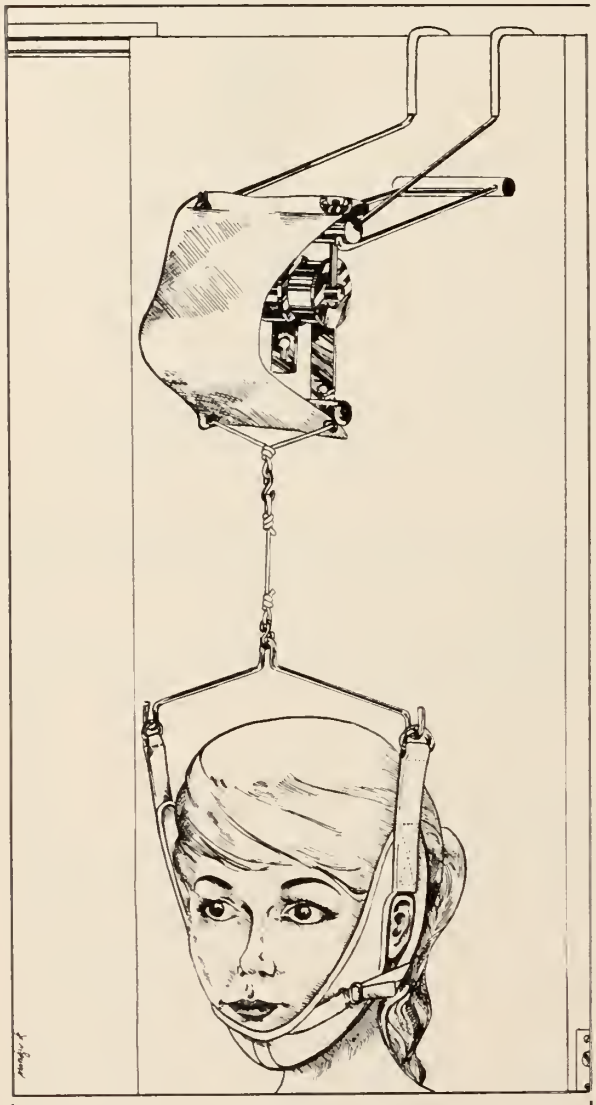
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IN MEMORIAM

RAYMOND C. ANDRIES, M.D., 79, Detroit practitioner for nearly 50 years and a former president of the American Medical Association, died July 9, 1963.

A graduate of Detroit College of Medicine, he practiced medicine in Detroit from 1907 until his retirement in 1953. He was AMA president in 1939 and was a founder of the American Board of Surgery and a charter member of the American College of Surgeons. Doctor Andries was professor of clinical surgery at Wayne State University College of Medicine from 1943 to 1948, president of the staff at Providence Hospital from 1930 to 1932 and consulting surgeon at Receiving Hospital from 1923 to 1930. He was on the staff of St. Mary's Hospital from 1907 to 1921.

Doctor Andries was a Life member of the Michigan State Medical Society.

HORACE R. COBB, M.D., 86, Kalamazoo physician since 1917, died June 23, 1963.

Doctor Cobb was Kalamazoo County coroner from 1925 until his retirement in 1956. He was president of the Michigan Coroners' Association in 1934.

He was a Life Member of the Michigan State Medical Society.

T. SIDNEY CONOVER, M.D., 59, Flint physician, died July 9, 1963.

A 1932 graduate of Western Ontario Medical College, Doctor Conover served his internship at Welfare Island, New York City. Doctor Conover was a member of the International College of Surgeons, founder of Liberty House, Inc., of Flint, which conducts group therapy programs in the areas of mental health and alcoholism, former director of the alcoholic group therapy program at Hurley Hospital, and a former member of the executive board of the Flint Committee on Alcoholism.

MILTON A. DARLING (See Page 850)

WALTER H. OBENAUF, M.D., 56, medical superintendent of Pontiac State Hospital, died July 17, 1963.



A 1947 graduate of Albany (N.Y.) Medical College, Doctor Obenauf interned at St. Lawrence Hospital, Lansing. From 1948 to 1951, he was a resident in psychiatry at Ypsilanti State Hospital, served as director of its outpatient clinic from 1951 to 1953, and became assistant medical superintendent of the hospital in 1953. In 1959, he became medical superintendent of Pontiac State Hospital.

Doctor Obenauf was treasurer of the American Psychiatric Association, past president of the Michigan Society of Neurology and Psychiatry, the Michigan

District Branch of the American Psychiatric Association and the Michigan Society of Neuropsychiatric Hospital and Clinic Physicians.

ROLLAND C. POCHERT, M.D., 64, Owosso, former councilor of the Michigan State Medical Society, died July 25, 1963.



A graduate of Detroit College of Medicine in 1921, Doctor Pochert served his internship and residency at Receiving Hospital, Detroit. A specialist in diseases of the eye, ear, nose and throat, Doctor Pochert practiced in East Tawas before moving to Owosso.

He was a member of Phi Beta Pi Medical Fraternity, The Academy of Ophthalmology and Otolaryngology, and a Fellow of the American College of Surgeons. He was on the staff of Memorial Hospital, Owosso, and a former chief of staff.

He served as councilor of the Michigan State Medical Society from 1945 to 1951.

HAROLD F. STAHL, M.D., 63, Oxford physician who delivered the famous Rosebush quadruplets, died July 25, 1963.

A graduate of the college of medicine at Toronto University, Doctor Stahl served his internship at Toronto General Hospital and Detroit's Harper Hospital, later joining the Harper staff. He was a deputy coroner for Oakland County and a member of the American Academy of General Practice.

Albion Home Care Project Explained

The Albion home care project, begun in 1960 with financial assistance from the W. K. Kellogg Foundation and the Michigan Department of Health, is described in the June, 1963, issue of *Hospital Management*.

Because home, not the hospital, is the most desirable place for sick patients to stay if medically possible, programs of home care have been established, the magazine reported in an article by Glen J. Durham and John R. Griffith, entitled "Community Cooperates for Home Care."

"The amount of treatment given in the first year was higher than the volume which would have been expected for the population served," the article says. The important considerations of the home care program are that it is cheaper and the patient and his family like it better.

Costs? "An average of $4 per day of patient contact" the magazine says. Noting that this may still appear to be high, "it is far less than the cost in nursing homes, which is often $10 per day in Michigan. It is obviously less than the cost of acute hospital care, which averaged $29.96 per day at the Sheldon Memorial Hospital in Albion."

Under the Albion plan, nursing is the most frequent service, followed by the physical and occupational therapies. The article concludes by noting a "likelihood" that the program has reduced the cost of patient care, "although this cannot be proved at this time."

"It is certain that some hospital days were saved by the use of home care. An equally significant number of days of care might have been saved in nursing homes."



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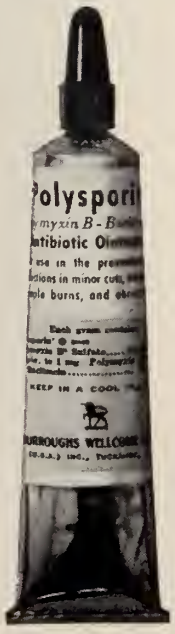
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The Doctor's Library

Acknowledgments of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review as expedient.

OBSTETRICS AND GYNECOLOGY. By J. Robert Wilson, M.D., Professor and Head of the Department of Obstetrics and Gynecology, Temple University School of Medicine and Temple University Medical Center, Philadelphia, Pa.; Clayton T. Beecham, M.D., Professor of Clinical Obstetrics and Gynecology, Temple University School of Medicine and Temple University Medical Center, Philadelphia, Pa.; Elsie Reid Carrington, M.D., Research Professor of Obstetrics and Gynecology, Woman's Medical College of Pennsylvania, Philadelphia, Pa. Second Edition. 333 illustrations. Saint Louis: C. V. Mosby Company, 1963. Price, $13.75.

This totally revised textbook of "Obstetrics and Gynecology" is still primarily for the medical student but is an excellent reference for the general practitioner.

The common operative techniques and the psychology and emotional difficulties of women in the field of obstetrics and gynecology have been included to make this book even more comprehensive. The expanded illustrations and bibliography further enhance the value of this edition.

One of the greatest advantages of this text is the unifying of gynecology with obstetrics rather than treating them as separate subjects, enabling the reader to correlate the material immediately instead of having to refer to previous chapters.

The chapters on pediatric gynecology and genetics are very well written and are placed toward the end of the book for the student's benefit.

J.R.P.

CANCER OF THE FEMALE REPRODUCTIVE ORGANS. By Alfred I. Sherman, M.D., Associate Professor of Obstetrics and Gynecology, Washington University School of Medicine; Director of the Gynecological Cancer Service at Washington University and Barnes Hospital Clinics; Consultant in Gynecology to the Mallinckrodt Institute of Radiology; Associate Obstetrician and Gynecologist to Barnes Hospital, St. Louis Children's Hospital, and Allied Hospitals; Consultant and Visiting Physician to City Hospital, Homer G. Phillips Hospital, St. Luke's Hospital, and Jewish Hospital, St. Louis, Mo.; Diplomate, American Board of Obstetrics and Gynecology. Illustrated by Elizabeth North. Saint Louis: C. V. Mosby Company, 1963. Price, $13.75.

This volume is a comprehensive treatise of cancer of the female reproductive organs—a book of greatest value to the gynecologist and general surgeon but is also an excellent reference for those in all fields of medicine.

The illustrations are entirely diagramatic which simplifies the understanding of the subject at hand. This is more pronounced in the subjects of radiation, isotopes and the physics of cancer therapy. Chemotherapy and surgical techniques are two very well written chapters. They are concise and sum up the present day knowledge of these subjects.

All chapters have excellent reference tables.

Of special interest is a section devoted to survival statistics with a very informative explanation of the statistics themselves.

J.R.P.

BABY AND CHILD CARE. By Benjamin Spock. Illustrations by Dorothea Fox. A Giant Cardinal Edition. New York: Pocket Books, Inc., 1963. Price, 50 cents.

A very informative book for mothers to have on hand. It relieves their minds and supplants the necessity to ask myriads of questions from their busy family doctor.

BOOKS RECEIVED

BEDSIDE DIAGNOSIS. Sixth Edition. By Charles Seward, M.D., F.R.C.P. (Edin.) Physician, Royal Devon and Exeter Hospital; Consulting Physician, Princess Elizabeth Orthopaedic Hospital, West of England Eye Infirmary and The Ministry of Pensions; Honeyman Gillespie Lecturer; Late Advisor in Medicine to Eastern Command, India; Late Deputy President, Review Medical Board, India. With a chapter on Some Uses of Radioactive Isotopes in Diagnosis by Mark Ridley, B.A., M.B., B.Chir. Forword by Lord Cohen of Birkenhead, M.D., D.Sc., LL.D., F.R.C.P., F.A.C.P., F.F.R., Professor of Medicine, University of Liverpool. Baltimore: The Williams and Wilkins Company, 1962. Price, $7.00.

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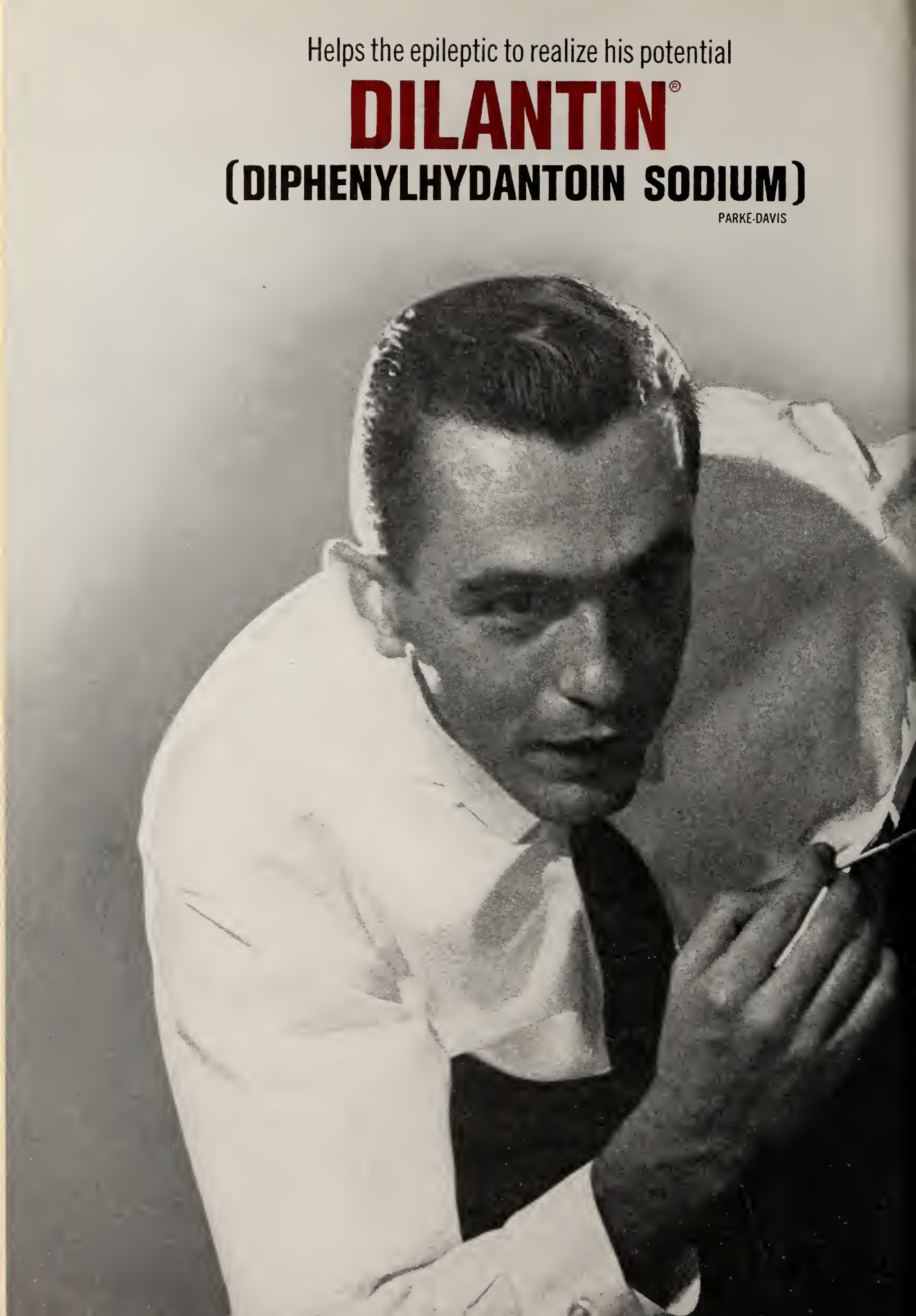
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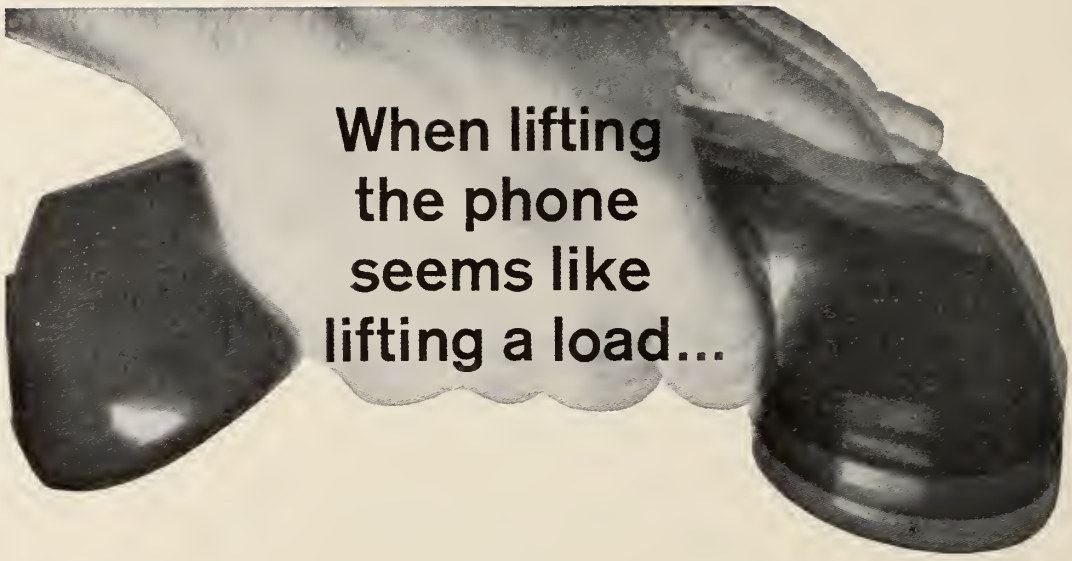
REFERENCES: (1) Hammill, J. F.: J. Chron. Dis. 8:448, 1958. (2) Roseman, E.: Neurology 11:912, 1961. (3) Bray, P. F.: Pediatrics 23:151, 1959. (4) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (5) Crawley, J. W.: M. Clin. North America 42:317, 1958. (6) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (7) Ibid.: Postgrad. Med. 20:584, 1956. (8) Merritt, H. H.: Brit. M. J. 1:666, 1958. (9) Carter, C. H.: Arch. Neurol & Psychiat. 79:136, 1958. (10) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (11) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.

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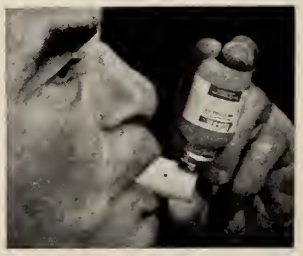
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1. Reeves, J. E.: *M. Times* 90:512, May, 1962. 2. Williams, M. H., Jr.: *M. Sc.* 11: 433, March 19, 1962. 3. Peckenschneider, L. E.: *J. Kansas M. Soc.* 56:486, Sept., 1955.

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All communications relative to exchanges, books for review, manuscripts, should be addressed to Publications Committee, Michigan State Medical Society, Box 152, East Lansing, Michigan.

All communications regarding advertising and subscriptions should be addressed to Wm. J. Burns, 120 W. Saginaw Street, East Lansing, Michigan. Telephone 337-1351 (Area Code 517).

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	Term Expires
J. R. Heidenreich, M.D., Daggett	1963
W. A. Hyland, M.D., *Chairman,* Grand Rapids	1963
O. J. Johnson, M.D., Bay City	1963
L. R. Leader, M.D., Birmingham	1963
C. I. Owen, M.D., Detroit	1964
G. W. Slagle, M.D., Battle Creek	1964
D. N. Sweeny, Jr., M.D., Detroit	1964

Alternates

	Term Expires
G. B. Saltonstall, M.D., Charlevoix	1963
J. M. Wellman, M.D., Lansing	1963
Sidney Adler, M.D., Detroit	1963
B. M. Harris, M.D., Ypsilanti	1963
R. E. Rice, M.D., Greenville	1964
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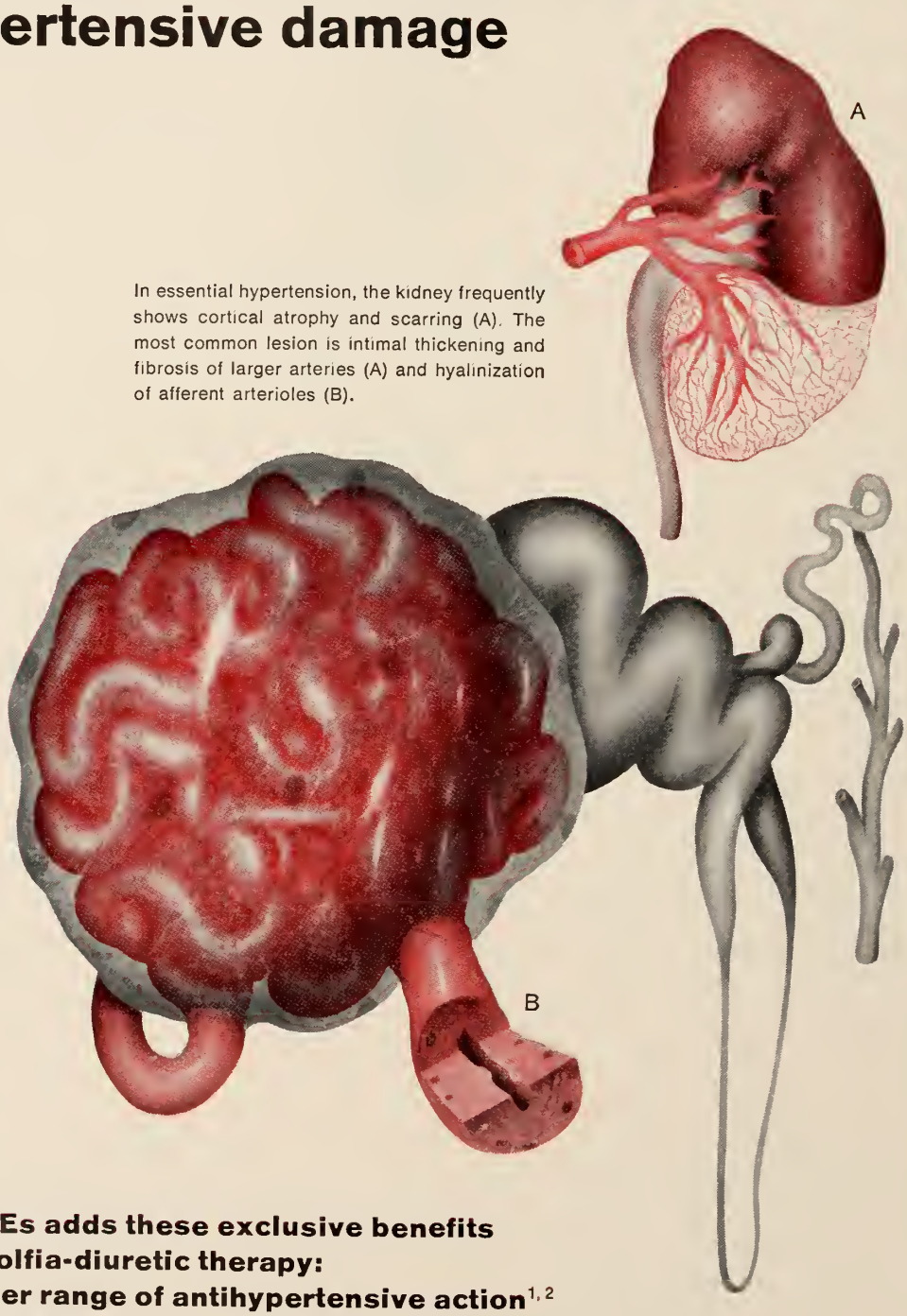
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References: 1. Hobbs, L. F.: Virginia Med. Monthly 90:28 (Jan.) 1963. 2. Dupler, D. A., Greenwood, R. J., and Connell, J. T.: J.A.M.A. 174:123 (Sept. 10) 1960. 3. Reubi, F. C.: Proc. Soc. Exp. Biol. Med. 73:102 (Jan.) 1950. 4. Kleh, J., and Fazekas, J. F.: Amer. J. Med. Sci. 227:57 (Jan.) 1954.

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President's Page

THE WORK OF MSMS IS YOUR WORK



Orlen J. Johnson M.D.

President
Michigan State Medical Society

Recently, a member asked me what MSMS does for him.

In the first place, this is a voluntary organization comprised of individuals with common interests. Those interests are broad with many facets. Originally, they were almost wholly scientific. Since this phase has become so complex, it is impossible for one organization or group to cover it in complete detail. Nevertheless, great and successful effort is made to do so.

With the development of sociologic, economic and political pressures on medicine, the profession has become embroiled in a maze of influences. County and state societies and the American Medical Association, being the fundamental organizations representing the profession as a whole, have been charged with performing outside the scientific field. Activities of this nature being more sensational and controversial make them appear as all-consuming projects of medical organizations. Nothing could be further from the truth.

What is the Michigan State Medical Society?

This voluntary society is made up of individual physicians banded together to WORK on their common problems and activities. It is that which keeps them functioning. After many years of close association and observation, I have nothing but admiration, appreciation and respect for the physicians who thus devote untold hours of work for the good of their patients, their fellow practitioners and their organizations.

AMA President Edward R. Annis made "Work" the keyword of his address to the AMA House of Delegates last June.

The accomplishments of medical organizations arise from the individual physician's efforts and spread upward. The result is a massive moving influence that could never be achieved without cohesive organization. True, there are many non-medical aides functioning or working in technical areas to assist in the implementation of policies determined by the medical members of the organizations, but the effective results of these policies depend wholly on the WORK and concerted activity of the individual physicians. It provides application of scientific advancements and as healthy a political climate as possible in which to practice.

The benefits from your medical societies are from the WORK you do.

Select New Leaders For MSMS, 1963-64



Orlen J. Johnson, M.D., Bay City, is the new President of the Michigan State Medical Society, installed at the 98th Annual Session at Grand Rapids, September 22-27.

James J. Lightbody, M.D., Detroit, continues as Speaker of the new MSMS House of Delegates.

Harold H. Hiscock, M.D., Flint, is the new Chairman of The MSMS Council, advanced from Vice Chairman.

These three men will lead the physicians during 1963-64, with Oliver B. McGillicuddy, M.D., Lansing, elected as the President-Elect. Doctor McGillicuddy had served as Chairman of The Council.

The Delegates returned Speaker Lightbody for another year, and chose Louis F. Hayes, M.D., Gaylord, to serve as Vice Speaker.

The House of Delegates also elected 11 Councilors. Chosen as new Councilors were Robert K. Whiteley, M.D., Grosse Pointe; Edward J. Tallant, M.D., Detroit; Ross V. Taylor, M.D., Jackson; Harold Kessler, M.D., Alpena; and Brooker L. Masters, M.D., Fremont. Re-elected as Councilors were W. C. C. Cole, Sr., M.D., Detroit; H. C. Hansen, M.D., Battle Creek; R. V. Daugharty, M.D., Cadillac; J. R. Dehlin, M.D., Gladstone; D. R. Smith, M.D., Iron Mountain, and R. J. Mason, M.D., Birmingham.

At the organizational meeting of The Council, Doctor Mason was named Vice Chairman. Renamed Chairman of the Publication Committee was William A. Scott, M.D., Kalamazoo; C. Allen Payne, M.D., Grand Rapids, was chosen the new Chairman of the Finance Committee, and Edgar E. Martmer, M.D., Grosse Pointe, new Chairman of the County Societies Committee.

Four MSMS Delegates to the AMA were re-elected—J. R. Heidenreich, M.D., Daggett; W. A. Hyland, M.D., Grand Rapids; O. J. Johnson, M.D., Bay City, and L. R. Leader, M.D., Birmingham. Re-elected as Alternate Delegates were Sidney Adler, M.D., Detroit; G. B. Saltonstall, M.D., Charlevoix; B. M. Harris, M.D., Ypsilanti, and chosen as a new Alternate Delegate was Lawrence Drolett, M.D., Lansing.

* * *

An unofficial summary of the 1963 House of Delegates action will appear in the November number of THE JOURNAL.

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Internal Medicine & Hematology

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1220 E. Gaylord St.
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Grand Rapids, Michigan
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915 S. College
Mt. Pleasant, Michigan
Pediatrics

Robert A. Bota, M.D.
602 Kensington Ave.
Flint, Michigan
Pathology

William A. Bow, M.D.
2031 N. Michigan Ave.
Saginaw, Michigan
Pediatrics

Frederick Brenner, M.D.
900 N. Jackson
Bay City, Michigan

James A. U. Carter, M.D.
16637 Wildemere
Detroit 21, Michigan

Frank Costa, M.D.
16805 Windmere Circle
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General Practice

R. A. Diccion, M.D.
Addison, Michigan

James E. Gotham, M.D.
3825 Brush Street
Detroit 1, Michigan
Neurology

Amado Grabiel, M.D.
10151 Michigan
Dearborn, Michigan
General Practice

George J. Hambalgo, M.D.
3210 Belle Court
Royal Oak, Michigan
Internal Medicine

James R. Irwin, M.D.
1022 Floral Drive, S.E.
Grand Rapids 6, Michigan
Obstetrics-Gynecology

John S. Jacoby, M.D.
522 Old Bridge Rd.
Grand Blanc, Michigan
Internal Medicine

Robert A. Janke, M.D.
1416 W. Milham Rd.
Kalamazoo, Michigan

Philip C. Karamatas, M.D.
13244 W. Warren
Dearborn, Michigan

Karl Kelawan, M.D.
Scottville, Michigan

Robert R. King, M.D.
261 Brady Street
Detroit 1, Michigan
Physical Medicine

John H. Lignell, M.D.
14200 Puritan
Detroit 27, Michigan

Jacob Mainzer, M.D.
36475 Five Mile Rd.
Livonia, Michigan
Anesthesiology

Robert E. Mines, Jr., M.D.
8401 Woodward Avenue
Detroit 2, Michigan

George M. Morley, M.D.
12922 W. Warren
Dearborn, Michigan
Obstetrics-Gynecology

Herschel E. Mozen, M.D.
12950 W. Chicago Ave.
Detroit 28, Michigan

Thomas J. Mudge, M.D.
Medical Building
Marquette, Michigan
Surgery

Robert C. Murdy, M.D.
Box A, Kalamazoo State Hospital
Kalamazoo, Michigan

Donald T. Olson, M.D.
17701 W. McNichols Road
Detroit 35, Michigan
Obstetrics-Gynecology

John Pierpont, M.D.
White Pine, Michigan

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10 Peterboro
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Carl J. Ponischil, M.D.
Rt. No. 1, Box 1305
Marquette, Michigan
Roentgenology-Radiology

Jack R. Price, M.D.
410 S. Ballenger Hwy.
Flint, Michigan
Obstetrics-Gynecology

Sidney Prystowsky, M.D.
1800 Tuxedo
Detroit 6, Michigan

Nancy H. Rausch, M.D.
11639 Turner
Detroit 4, Michigan
Cardiovascular Diseases

Raymond W. Rebandt, M.D.
2615 W. Jefferson
Trenton, Michigan
Surgery

Richard C. Reilly, M.D.
880 Woodward Ave.
Pontiac, Michigan
Orthopedic Surgery

Richard E. Ruel, M.D.
1515 David Whitney Bldg.
Detroit 26, Michigan
Gastroenterology and Internal Medicine

Donald S. Schaefer, M.D.
1416 W. Milham Rd.
Kalamazoo, Michigan

Carole Sue Schaffer, M.D.
St. Lawrence Hospital
Lansing, Michigan
General Practice

Parviz Sham-Avari, M.D.
25210 Grand River
Detroit 40, Michigan

Joseph L. Sheets, M.D.
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Obstetrics-Gynecology

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Oral Surgery

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Ishpeming, Michigan
Obstetrics-Gynecology

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it's versatile: The years have proved that 'Miltown' (meprobamate) is the one tranquilizer that is helpful in almost every aspect of daily practice. Virtually any of your patients, regardless of age, can be given the drug with confidence, either as a primary treatment or as an adjunct to other therapy. **Outstanding record of safety:** Over eight years of clinical use among millions of patients throughout the world — plus more than 1500 published reports covering the use of the drug in almost every field of medicine — support your prescriptions for 'Miltown' (meprobamate). This is why it *"belongs in every practice."*

dependable: 'Miltown' (meprobamate) is an established drug. There are no surprises in store for you or your patient. You can depend on it to help your patients through periods of emotional distress — and to help maintain their emotional stability.

easy to use: Because 'Miltown' (meprobamate) is compatible with almost any other kind of drug therapy, you'll find it fits in easily with any program of treatment you are now using. It will not, therefore, complicate treatment of patients seen in clinical practice.

BRIEF SUMMARY: *Indications:* Anxiety and tension states, and all conditions in which anxiety and tension are symptoms. *Side Effects:* Slight drowsiness may occur and, rarely, allergic or idiosyncratic reactions, generally developing after 1-4 doses of the drug. *Contraindications:* Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. *Precautions:* Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities, to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available to physicians on request.*

USUAL ADULT DOSAGE: 1 or 2 400 mg. tablets t.i.d.

SUPPLIED: 400 mg. scored tablets, 200 mg. coated tablets.

GM-9694

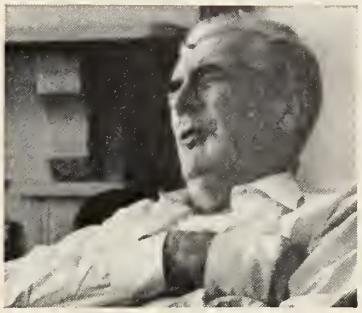
Say you saw it in the Journal of the Michigan State Medical Society



The insomniac



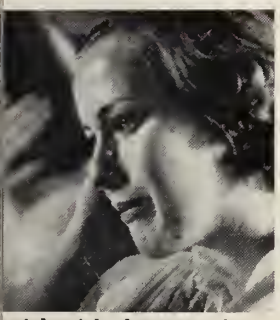
The tense, nervous patient



The heart-disease patient



The surgical patient



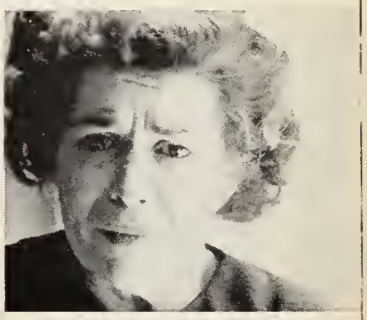
girl with dermatosis



Tension headache



The woman in menopause



Anxious depression



emenstrual tension



The agitated senile patient



The alcoholic



The problem child

the original brand of
meprobamate

Miltown®



The G.I. patient

WALLACE LABORATORIES
Cranbury, N.J.



PASS me the

Soyalac

Fibre-free HYPOALLERGENIC formula

1. Provides balanced nutritional values.
2. An excellent formula for regular infant feeding.
3. An ideal food for milk allergies, eczema and problem feeding.

SOYALAC helps solve the feeding problem of prematures and infants requiring milk-free diet.

Strikingly similar to mother's milk in composition and ease of assimilation, babies thrive on SOYALAC.

Clinical data furnish evidence of SOYALAC'S value in promoting growth and development.

Protein of high biologic value is obtained from the soybean by an exclusive process.

Free Booklet and Samples

A request on your professional letterhead or prescription form will bring to you complete information, and a supply of samples.



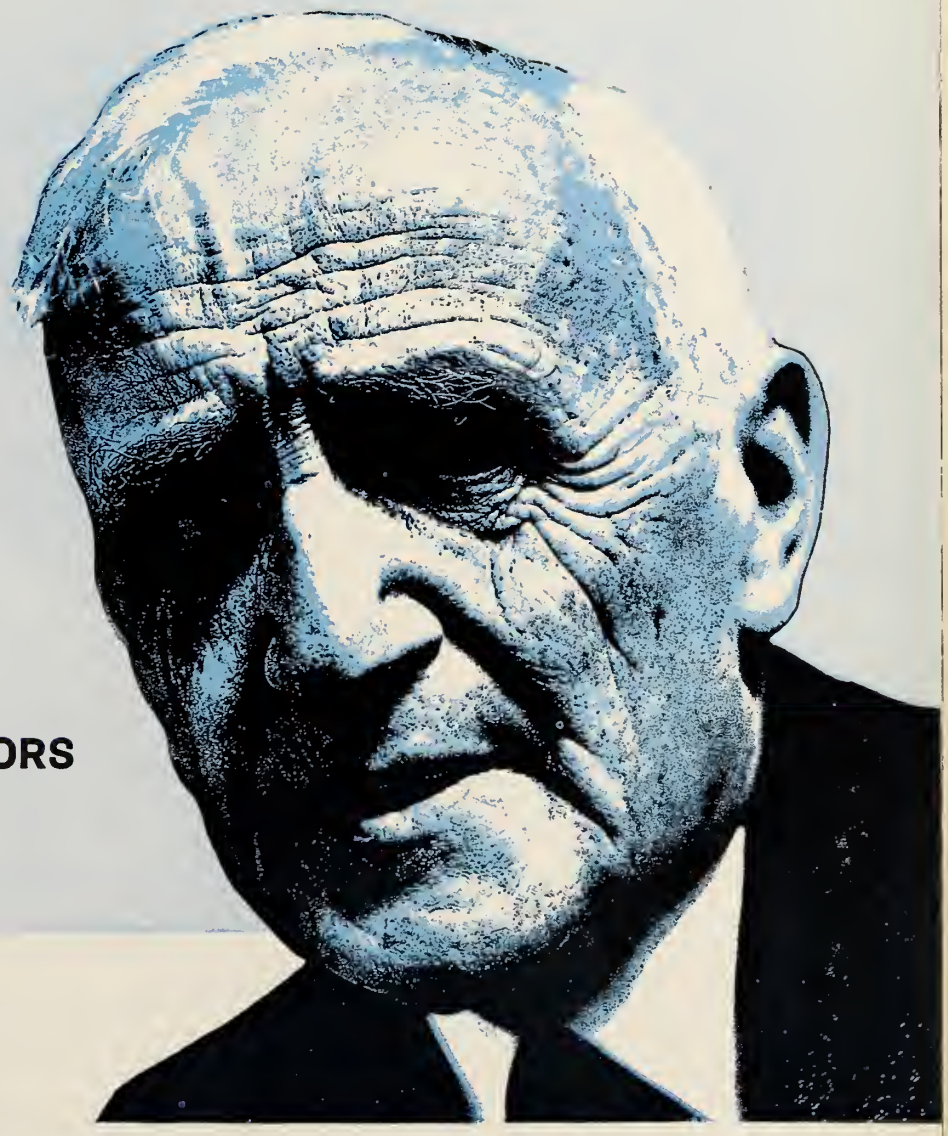
Medical Products Division

LOMA LINDA FOODS

RIVERSIDE, CALIFORNIA

Mount Vernon, Ohio • Oshawa, Ontario-Canada

For your elderly arthritic patients



AN EFFECTIVE GERIATRIC ANTIARTHRITIC WITH ESSENTIAL SAFETY FACTORS

safely indicated – even in the presence of **HYPERGLYCEMIA**

PABALATE-SF may be prescribed with confidence to elderly arthritics—even in the presence of hyperglycemia—because of its widely recognized **Safety Factors:** (1) its potassium salts cannot contribute to sodium retention; (2) its enteric coating assures gastric tolerance; and (3) its use is free from the serious reactions in diabetic patients sometimes noted during therapy with steroids or pyrazolone derivatives. As for effectiveness, it has been found "superior to aspirin in the treatment of chronic rheumatic disorders."[1]

Each persian-rose enteric-coated tablet contains: potassium salicylate, 0.3 Gm.; potassium para-aminobenzoate, 0.3 Gm.; ascorbic acid, 50 mg.

1. Ford, R. A., and Blanchard, K. P.: J.-Lancet 78:185, 1958.

Precaution: Occasionally, mild salicylism may occur, but this responds readily to dosage adjustment. In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Supply: Bottles of 100 and 500 enteric-coated tablets.

Pabalate®-SF

Robins

(the new, convenient way to prescribe Pabalate-Sodium Free)

A. H. ROBINS COMPANY, INC., RICHMOND, VIRGINIA

blood, milk and Maalox®

(magnesium-aluminum hydroxide gel)

Practically standard treatment, now, for bleeding ulcer. Why is Maalox included? Antacid therapy *must* continue long after the wound has healed, and patients started on Maalox tend to stay on Maalox. It tastes good; it's effective and will not cause constipation—three important reasons for Maalox over the long haul. Some physicians, we are told, order Maalox routinely for hospital patients on drugs which could irritate. They feel it reduces the likelihood of gastric discomfort. Supplied: Suspension; Tablets No. 1; Tablets No. 2. (Each Maalox No. 1 Tablet is equivalent to 1 teaspoonful and each Maalox No. 2 Tablet is equivalent to 2 teaspoonfuls of Suspension.)



R O RORER E R WILLIAM H. RORER, INC., FORT WASHINGTON, PA.



*This one in the High Sierras, California

...nothing, that is, except the sedative-antispasmodic action of

Donnatal®

In each Tablet, Capsule or 5 cc. Elixir		In each Extentab
0.1037 mg.	hyoscyamine sulfate	0.3111 mg.
0.0194 mg.	atropine sulfate	0.0582 mg.
0.0065 mg.	hyoscine hydrobromide	0.0195 mg.
16.2 mg. (¼ gr.)	phenobarbital	(¾ gr.) 48.6 mg.

(Warning: May be habit forming)

No serious toxic reactions are to be anticipated. Dryness of the mouth, blurred vision, difficult urination, and flushing and dryness of the skin may occur with excessive and prolonged dosage, but promptly disappear with reduction in dosage. Contraindicated in acute glaucoma, advanced hepatic or renal disease, or idiosyncrasy to any component. Use with care in incipient glaucoma or urinary bladder neck obstruction.

A. H. ROBINS CO., INC., Richmond 20, Virginia

Prescribed by more physicians than any other antispasmodic—*well over 5 billion doses!*

when 'pain & spasm'



call for analgesic-relaxant action···

Whether spasm is induced by pain, or pain by spasm, satisfactory control usually requires analgesic as well as relaxant action. In such cases, ROBAXISAL combats both pain and spasm. When apprehension is a complicating factor, ROBAXISAL-PH is indicated.

Among the many conditions for which ROBAXISAL and ROBAXISAL-PH have been found effective are: strains and sprains, painful disorders of the back, "whiplash" injury, myositis, pain and spasm associated with arthritis, low back pain, torticollis, and headache associated with muscular tension.

Side effects such as lightheadedness, slight drowsiness, dizziness and nausea may infrequently occur but usually disappear on reduction of dosage. There are no specific contraindications other than hypersensitivity to any one of the components.

*Skeletal muscle spasm is a two-headed dragon of 'PAIN & SPASM'



ROBAXISAL®

Each pink-and-white laminated Tablet contains:

ROBAXIN (methocarbamol, Robins)	400 mg.
U.S. Pat. No. 2770649	
Aspirin (5 gr.)	325 mg.

ROBAXISAL-PH

Each green-and-white laminated Tablet contains:

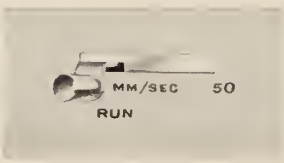
ROBAXIN (methocarbamol, Robins)	400 mg.	Hyoscyamine sulfate	0.016 mg.
Phenacetin	97 mg.	Phenobarbital (1/8 gr.)	8.1 mg.
Aspirin	81 mg.	(Warning: May be habit forming)	

Robins

A. H. ROBINS CO., INC., Richmond 20, Virginia



added capabilities in a cardiograph . . . with the Sanborn "100 Viso"



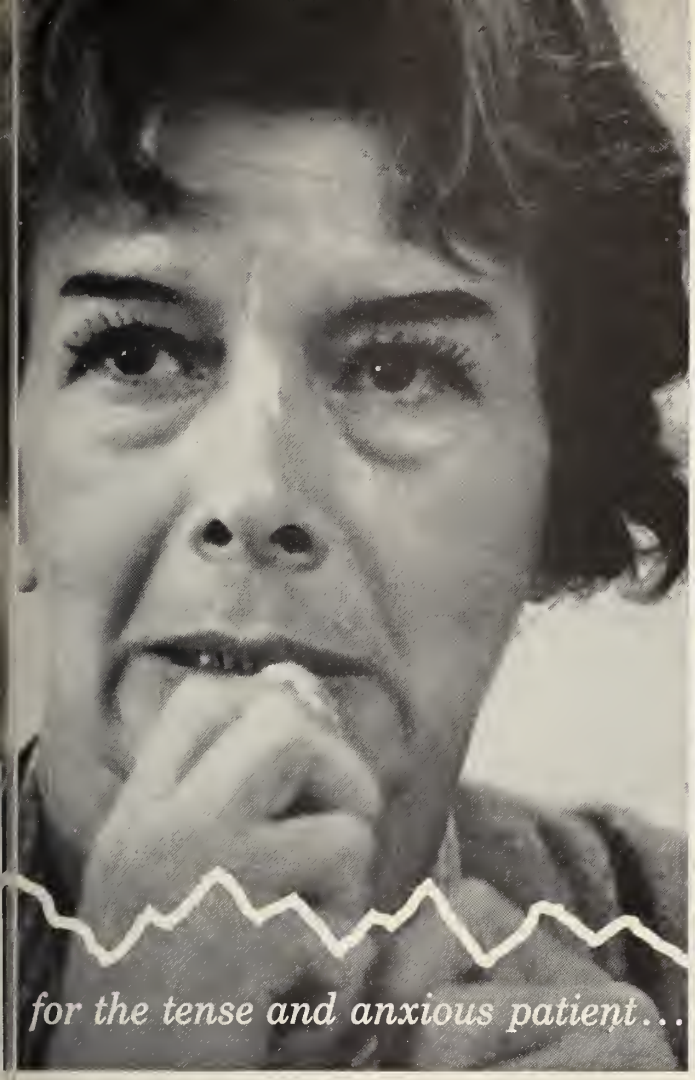


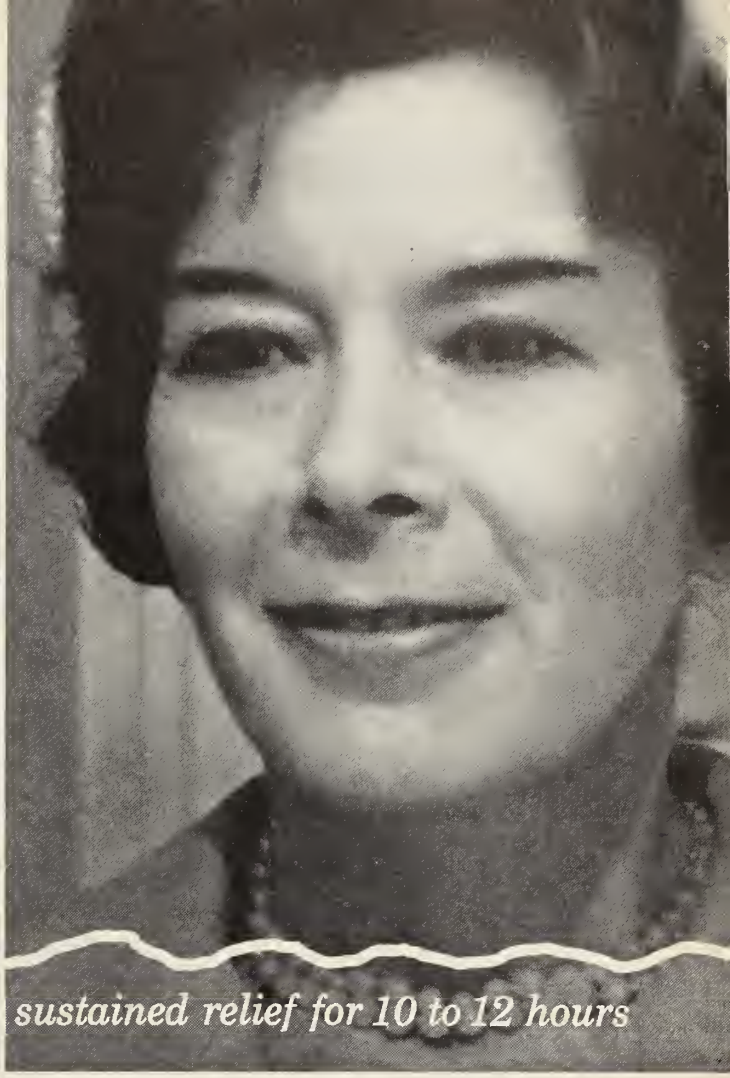
All electrocardiographs produce a graphic record to aid you in your diagnosis, but the Sanborn "100 Viso" and its mobile "100M" version add two significant capabilities to this basic ECG function: complexes can be "expanded" in time by running the chart at 50 mm/sec. instead of 25 mm/sec., and amplitude or height of the tracing can be adjusted to suit the leads being recorded (sensitivity can be set at normal, one-half normal or twice the normal value). Provision is also made for connecting a scope for signal display, and for recording other physiologic phenomena.

Coupled with world-famous Sanborn cardiograph dependability, precision and locally-available supplies — and the exclusive 15-Day No-Obligation Trial Plan — these 100 and 100M Viso-Cardiette advantages can make a significant difference in ECG value to you. Your nearby Sanborn man can provide full details, or write the main office.

SANBORN COMPANY
Medical Division, Waltham 54, Mass.

DETROIT *Branch Office* 13136 Puritan Ave., University 4-6336, 4-6337





Smooths out emotional peaks and valleys

'Meprospan'-400 brand of meprobamate contains 400 mg. in sustained-release form. One capsule smooths out the anxious patient's emotional peaks and valleys for 10 to 12 hours — and provides these other advantages:

1. **Especially suitable for maintenance therapy.** Patients whose anxiety has diminished to a mild or moderate level still require a certain amount of tranquilization throughout the day. Sustained-release action is ideally suited to this type of patient.
2. **Simpler dosage schedule.** Since one capsule of 'Meprospan'-400 (meprobamate, sustained release) acts 10 to 12 hours, the patient enjoys a much simpler dosage schedule than with tablets — and is less likely to forget to take the medicine.

Side Effects: Rarely, skin reactions. May increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence in patients with history of drug or alcohol addiction.

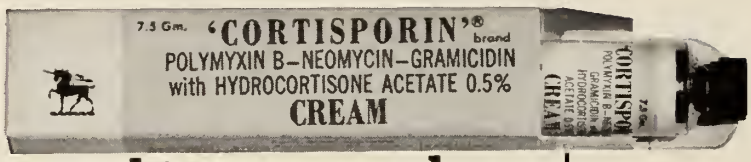
Available: *'Meprospan'-400* (meprobamate, sustained release) contains meprobamate 400 mg. *'Meprospan'-200* (meprobamate, sustained release) contains meprobamate 200 mg. Both potencies in bottles of 30. **Usual dosage:** One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Meprospan®-400
meprobamate 400 mg.
sustained release

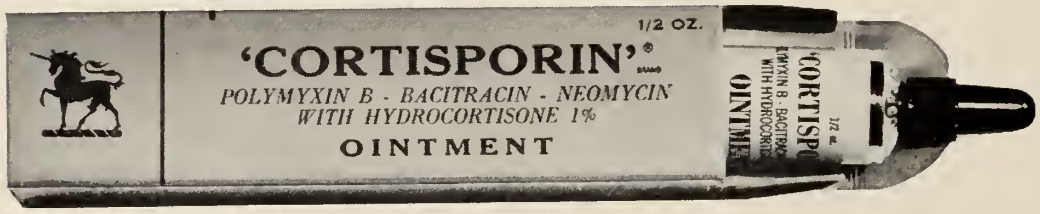
WALLACE LABORATORIES / *Cranbury, N.J.*

CME-9188

CHOOSE THE PRODUCT TO FIT THE NEED



a new vanishing cream base



a special low melting point base

anti-inflammatory
bactericidal
antipruritic
rarely sensitizing

CREAM—*Ingredients:* Each gram contains 'Aerosporin'® brand Polymyxin B* Sulfate 10,000 Units; Neomycin Sulfate (equivalent to 3.5 mg. Neomycin Base) 5.0 mg.; Gramicidin 0.25 mg.; Hydrocortisone Acetate 5.0 mg. (0.5%).

In a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax, distilled water, and 0.25% methylparaben as preservative.

Available: In tubes of 7.5 Grams.

OINTMENT—*Ingredients:* Each gram contains 'Aerosporin'® brand Polymyxin B* Sulfate 5,000 Units; Zinc Bacitracin 500 Units; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. Neomycin Base); Hydrocortisone 10 mg. (1%).

In a special white petrolatum base.

Available: In tubes of ½ oz. and ⅛ oz.

*U.S. Patent Nos. 2,565,057–2,695,261

Indications: Wherever inflammation or infection occurs and is accessible for topical therapy.

Contraindications: These drugs are contraindicated in tuberculous, fungal or viral lesions (herpes simplex, vaccinia and varicella).

Caution: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Complete literature available on request from Professional Services Dept. PML.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Important news in cardiac therapy

Two new clinical reports document successful long-term treatment of ischemic heart disease with Persantin,® brand of dipyridamole

See next 3 pages

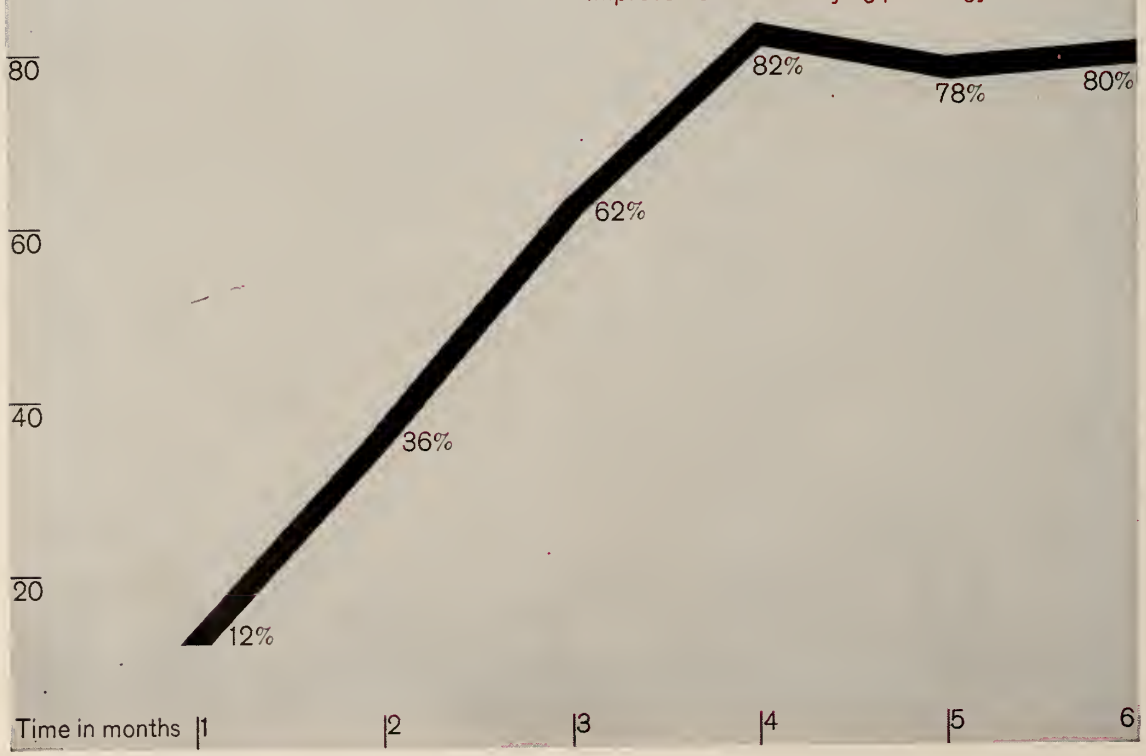
Study 1.
Griep,A.H.: Long-term Therapy of Ischemic Heart Disease With Oral Dipyridamole:
A Report of Fifty Cases. Angiology 14:484, 1963.

Persantin,® brand of dipyridamole, 25 mg. t.i.d. or q.i.d.,was administered continuously for 6 months to 50 patients with well authenticated ischemic heart disease with angina pectoris and ECG abnormalities. Results were evaluated on a monthly basis; final evaluation after 6 months showed that 56% of patients were completely free of, or had markedly fewer, anginal attacks, with normal or improved ECG findings; an additional 24% experienced fewer, milder attacks and improved work capacity.

Persantin®
brand of dipyridamole

"...long-term oral therapy with dipyridamole was of benefit in 80 per cent of the patients... relief [of angina] came slowly and was usually maximal after three to six months of continuous treatment"

Steady, month-by-month improvement with Persantin,® brand of dipyridamole, refutes possibility of "placebo response", reflects gradual improvement in underlying pathology.



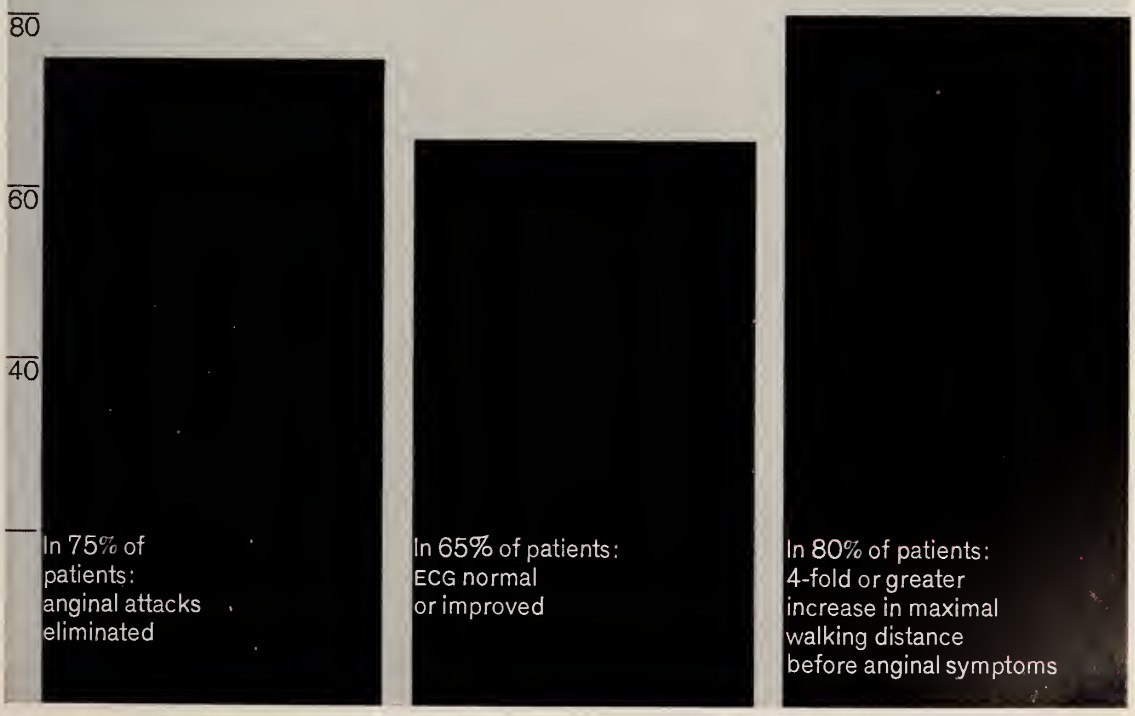
Study 2.
Wirecki,M.: Dipyridamole (Persantin®): Evaluation of Long-Term Therapy in Angina Pectoris. Current Therapeutic Research 5:472, 1963.

In 40 ambulatory patients with myocardial ischemia, angina pectoris, and abnormal ECG findings, Persantin,® brand of dipyridamole, 25 mg. t.i.d., was administered continuously for 3 months.

Results after 3 months of therapy revealed a satisfactory clinical response in 32 patients. The accompanying diagram illustrates the specific criteria of improvement in patients with excellent or good response.

Of 40 patients, 32 showed "...reduction or abolition of acute anginal attacks...complete or almost complete disappearance of ECG abnormalities... marked increase" in walking distance without anginal symptoms

Response after 3 months of continuous therapy with Persantin,® brand of dipyridamole



How Persantin,® brand of dipyridamole, provides long-term clinical benefits reported on previous pages

1. By increasing energy yield
of the hypoxic myocardial cell, by direct action upon the sarcosomes (heart mitochondria).[1-5]

2. By improving collateral coronary circulation.
Prolonged oral administration of dipyridamole to animals with experimentally induced stenosis of a major coronary artery resulted in superior development of collateral coronary anastomoses and longer survival compared with controls.[6-9]

When given for prolonged periods and in adequate dosage, dipyridamole improves the coronary flow deficit of the ischemic myocardium while supporting cardiac metabolism during the period of repair. Clinically, this is manifested as steady improvement – anginal attacks diminish in frequency and intensity, as do other manifestations of insufficiency (dyspnea, fatigue, and, in many instances, abnormal electrocardiographic findings).

Availability:
Tablets of 25 mg., bottles of 100 and 1000.
Under license from Boehringer Ingelheim G.m.b.H.

Prescribing summary: Persantin,® brand of dipyridamole, is indicated in coronary and myocardial insufficiency, in a dosage of 2 to 6 tablets daily in divided doses before meals for several weeks. Side effects (headache, dizziness, nausea, flushing, weakness, syncope, mild gastrointestinal distress) are minimal and transient. The drug is not recommended in the acute phase of myocardial infarction, and should be used cautiously in hypotension.

References: 1.Kunz,W.;Schmid,W.,and Siess,M.: Arzneimittel-Forsch.12:1098,1962. 2.Siess,M.: Arzneimittel-Forsch.12:683,1962. 3.Laudahn,G.: Experientia 17:415,1961. 4.Lamprecht,W.: 27th Congress of the German Society for Circulation Research,Bad Nauheim,1961. 5.Hockerts,T.,and Bögelmann,G.: Arzneimittel-Forsch.9:47,1959. 6.Vineberg,A.M.,et al.: Canad.M.A.J.87:336,1962. 7.Chari,S.R.et al.: Presented at the International Congress of Chest Physicians,New Delhi,1963. 8.Neuhaus,G.,et al.: Presented at the Fourth World Congress of Cardiology,Mexico City,1962. 9.Asada, S.,et al.: Japanese Circ.J.27:849,1962.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York, Distributors

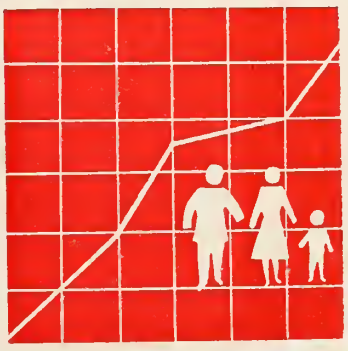
PE-2254

Say you saw it in the Journal of the Michigan State Medical Society

An Approach To Physician Pensions

By H. J. McLaurin
Special Consultant to Michigan State Medical Society

SOCIO ECONOMICS 963



Physicians of Michigan have a choice to make in selecting the approach to tax-sheltered pensions best suited to individual needs. Each physician should not only weigh the pros and cons of the many methods now being offered for self-employed pensions (Keogh Law) . . . but should also carefully consider the possibility of substantially more favorable tax treatment offered by a professional corporation. The Federal Self-Employed Individuals Act of 1962 (Keogh Law) and the Michigan Professional Service Corporation Act of 1962 are law.

Final revised regulations on Section 7701 (a) of the Internal Revenue Code which gives corporate tax status to professional corporations and associations have been promised by the Treasury Department in the near future.

* * *

THESE NEW LAWS vitally affect each physician in the State of Michigan, his family's security, and his future ability to accumulate funds for a comfortable retirement. It is possible for a single physician, under Michigan law and the Federal tax regulations on corporate pension plans, to form a professional service corporation and establish a tax-qualified corporate pension plan for himself . . . and enjoy other corporate benefits as an employee of the corporation.

Insurance companies, mutual funds, and other national organizations have prepared or are preparing Self-Employed Pension Plans. The Federal Government has also developed a special bond issue as an investment for these plans. In addition, the larger state banks are offering investment trusts for Self-Employed Pensions. In short, there is a wealth of information and plans for Self-Employed Pensions. But this only provides an answer to one-half of the real question facing Michigan physicians: Self-Employed Pensions *or* Professional Corporation Pensions?

From a practical point of view, this question can only be answered by taking a two-dimensional view (taxes and benefits) of both sides of the question . . . preferably at the same time to assure a valid comparison. Legally, this is only practical at the state level, because the Federal Income Tax Code for professional corporation pensions is interpreted in terms of individual state laws governing professional corporations or associations within each state. For example, thirty-one states have now enacted either professional corporation or association laws which differ in their approach and application. Illinois has a professional association law which requires two or more members of a profession to form a corporate-taxed association . . . while only one member of a profession is required for a professional service corporation under Michigan Law.

Mr. McLaurin is President, McCoy, McLaurin & Lackey, Inc., Detroit.

ILLUSTRATION OF TAX ADVANTAGES

Years	Unsheltered Tax Investment		Self-Employed Pension		Professional Corporation Pension	
	Non Tax Deductible Contribution	Federal Income Tax Savings	½ Tax-Deductible Contribution	Federal Income Tax Savings	Full Tax-Deductible Contribution	Federal Income Tax Savings
1	$ 2,025	—0—	$ 2,500	$ 475	$ 3,200*	$ 2,100
5	11,749	—0—	15,383	2,375	19,691	6,000
10	26,742	—0—	36,950	4,750	47,308	12,000
15	45,880	—0—	67,220	7,125	86,042	18,000
20	70,308	—0—	109,663	8,500	140,369	24,000
25	101,473	—0—	169,190	11,876	216,565	30,000

*The Federal Income Tax Law for corporate pensions places no maximum dollar limitation on tax deductible contributions. The $3,200 contribution assumed might very well have been more if the physician's financial condition in this illustration had warranted it.

NOTE: Illustration based on 1962 Federal Income Tax rates for a physician with net earnings of $28,000 a year from his practice. He is age 40, married with two children. He files a joint tax return with itemized deductions and exemptions totaling $5,200. After Federal Income Taxes of $6,344 and living expenses of $19,631, he has $2,025 to set aside for an unsheltered tax investment.

A 7 per cent investment return from a split bond and common stock portfolio is assumed in accumulating the tax exempt investment income from contributions under the Self-Employed and Professional Corporation Pension. Since investment income is taxable under the unsheltered investment, 5 per cent net after taxes was used to accumulate the nondeductible contributions to the unsheltered investment over the 25 years remaining until the physician reaches age 65.

BECAUSE OF THESE practical limitations to national plans and the advantages offered by state-wide service directed to the individual physician's needs, the Michigan State Medical Society has undertaken a study of a plan based on the following objectives:

1. Plan must give each member a means of selecting either self-employed or Corporate Pensions which are best suited to individual needs.

2. Plan must have flexible eligibility and investment provisions to the degree necessary to secure maximum tax-deductible contributions and optimum results for each member.

3. Plan must offer both Self-Employed and Professional Corporation Pensions in such a way as to assure a factual and valid comparison . . . not favoring one plan over the other.

4. Plan must offer demonstrated cost savings to each member through group participation, fees of establishing plan, and administrative cost.

5. Plan must provide means for supervision by elected members of the State Society acting as trustees or a board of governors to assure the operation of the plan in the best interest of each member.

6. Plan administration must provide means for state-wide service directed to the individual member needs.

7. Plan must be self-sustaining and completely voluntary.

8. Plan must be simplified as far as possible to reduce to a minimum "red tape" of the documents and forms necessary for each member to establish the plan and file for tax qualification.

Both Self-Employed and Professional Corporation Pensions offer members a means of making tax deductible contributions to reduce current income tax . . . and, at the same time, benefit from tax exempt investment income on the funds contributed. Either choice will make a marked difference in the future financial security of each member. The illustration on the following page shows the unique advantages of a plan offering both self-employed and corporate pensions, which would offer all members the most comprehensive pension service now available.

In addition to the different tax deductible results produced by Self-Employed and Professional Corporation Pensions, there are other major differences in the amount of pension, degree of plan flexibility, and other tax benefits.

Highlights of some of these major differences are outlined as follows:

	Self-Employed	*Profession Corporation*
A. *Coverage*	Must cover all full-time employees with three years or more of service.	No mandatory coverage requirement. Coverage based on classification which does not prohibitively discriminate in favor of higher ups. Requirements for employees to have at least five years' service minimum age 30, maximum age 55 are not considered prohibitively discriminatory. Within the limits of immediate coverage for all employees and the above requirements, corporation has large measure of freedom in establishing coverage requirements.

	Self-Employed	*Profession Corporation*
B. *Amount of Pension*	Amount of pension limited by the employer's and employee's contributions and the age at which the physician is covered under the plan. Younger physicians would receive much larger pensions.	No limit on reasonable amount of pension in relation to earnings so long as benefits are not prohibitively discriminatory in favor of higher ups. Younger and older physicians can receive same proportionate pensions in relation to earnings regardless of age.
C. *Employers' Contribution*	Physician can only contribute on his own behalf up to 10 per cent of his earnings or $2,500, whichever is smaller. Contributions for employees must be proportionate to physician's. (Ex.: Physicians can't contribute 10 per cent on his own behalf and 5 per cent for employees.)	No maximum limitation on amount of contribution allowed in any one year.
D. *Optional Employee's Contribution*	Physician and employees may make additional personal contributions which are not tax deductible. However, physician must make personal contributions which are proportionate to his employees', subject to a limit of the lesser of 10 per cent of earnings or $2,500, whichever is smaller.	Employee contributions permitted which are not tax deductible.
E. *Maximum Tax Deductible Limit*	Physician can deduct only one-half of contributions made on his own behalf. He can deduct all contributions made on behalf of his employees up to same limit which applies to corporate plans. Deduction figured on year-to-year basis. No excess contribution carry over. Penalties apply if contributions for physician exceed allowable amount.	Maximum tax deductible contribution allowed in one year, either: (a) 5 per cent of pay of covered employees plus any sum necessary for actuarily determined cost, or (b) Normal cost plus 10 per cent of lump sum past service cost, or (c) 15 per cent of pay of covered employees for profit sharing plan. Tax deductible carry over for excess contributions.
F. *Vesting*	100 per cent immediate vesting benefits for all employees.	100 per cent, 50 per cent, et cetera, or no vesting can be provided under plan. Lack of vesting does not produce prohibitive discrimination, but 100 per cent vesting is required if plan is ever terminated.
G. *Payment of Benefits*	No benefits payable to physician before age 59½, disability, or death. Benefits for physicians must begin not later than age 70½. These rules do not apply to a physician owning less than 10 per cent of a practice, and there are no specific restrictions as to the earliest and latest date employees can begin to receive benefits. Penalty applies to premature distribution.	No restrictions on the payment of benefits at retirement, disability, death, discharge, or quit.
H. *Lump Sum Distribution*	No capital gain tax for physician. Distribution after age 59½, disability or death taxed under special method much less liberal than capital gains.	Capital gain tax allowed for all employees including physician employees of professional corporation.
I. *Estate, Gift and Income Tax*	Physicians cannot quality for these exclusions: (a) Estate Tax. (b) Gift Tax. (c) $5,000 Death Benefit. (d) $100-a-week sick pay. Both physician and employees for retirement income Federal Income Tax credit.	All employees including physician employee of professional corporations qualify for these tax benefits. Both physician and employees eligible for retirement income Federal Income Tax credit.
J. *Types of Plans*	Generally what is known as a "money purchase" plan is the only practical type plan for physicians. However, a physician who must cover his employees may prefer a profit-sharing plan which may be established under the new law. No profit; no contribution. Group insurance for physician not tax deductible.	All types of plans are available to corporations. Plus, a corporation may establish both a profit sharing and retirement plan to maximize tax deductible contributions in good profit years. Group insurance tax deductible.

IN CONJUNCTION WITH the Michigan State Medical Society's study of pensions, the legal council for the Society is preparing a recommended guide for members and their attorneys to follow if they elect to establish a professional service corporation which will qualify for corporate pensions. The guide will be specially designed to qualify under Michigan Law and the Federal Income Tax Regulations on corporate pension plans. The use of a recommended guide and the adoption of a plan designed especially for Michigan physicians should assure each member qualification of his plan with the Internal Revenue Service as effectively and promptly as possible.

The Michigan State Medical Society plans to have the results of its study completed in the next few months. Upon approval by the Society, it is proposed that the Plan be adopted as far as possible in advance of December 31, 1963, to provide all members with sufficient time to adopt the Plan and make tax deductible contributions for 1963.

Controls, Controls

A group of 140 pharmaceutical firms who collectively manufacture more than 90 per cent of the nation's prescription products have accused the FDA of seeking to censor all medical journal drug advertising. The 140 firms, represented by the Pharmaceutical Manufacturers Association, claim that the regulation, issued June 20, 1963, by the FDA, goes beyond the scope and intent of the 1962 drug amendments act. In the act, Congress specified that "prior approval" would be required only in "extraordinary circumstances."

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1962 Health Cost Figures Released for United States

Because Americans are more health conscious than ever before, because new treatments and medications are now available, and because prepayment health care plans are broader in scope, Americans spent 7.6 per cent more in 1962 than in 1961 to maintain their health and to remedy their ailments.

The 1962 figures show that Americans spent a total of $22.7 billion, or an increase of 7.6 over 1961. This was an average of $124 for each man, woman and child.

The breakdown of expenditures reveals that almost one-third was spent on hospital treatment. Seven billion went to hospitals, $6.6 billion to physicians; $5.6 billion for medicines and appliances; $2.2 billion on dental services and $1.3 billion on other costs including nursing home care and non-professional practitioners.

The figures, released by the national Health Insurance Institute, reveal also that:

(1) The average length of stay in the hospital for each patient was 7.6 days—down from 8.1 in 1952.

(2) The average cost per hospital stay was $279.91.

(3) The average cost per hospital day was $36.83.

(4) The average American saw his physician five times in 1962.

For all their health needs, Americans spent 6.4 per cent of their total outlay. The health care bill in 1952 was 4.6 per cent of their total outlay, and 4 per cent 25 years ago.

You'd Cry, Too

Senator Everett Dirksen (R.-Ill.) says he knows a man who got off a hospital elevator on the wrong floor, which happened to be the maternity ward. The visitor noticed that many of the babies were crying in their cribs, so he asked a nurse what was wrong.

"Nothing," replied the nurse. "You'd cry too if you just arrived and found out you owed the Federal Government eighteen hundred dollars on the national debt and had wet pants."—WALTER TROHAN, *Chicago Tribune* Press Service.

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County Societies Push Community Health Week

"Community Health Week" will be observed in communities across the state, October 20-26, to focus public attention "on the progress of medical science and the high quality of community health resources and facilities."

The new project, endorsed by AMA in Los Angeles a year ago, will be directed in Michigan by the Michigan Health Council, Michigan State Medical Society and the Michigan Association of the Professions.

Joseph R. Lentini, M.D., Grand Rapids, is serving as general chairman.

As the actual week nears, Doctor Lentini stresses that "The success of this program will depend largely upon the effectiveness of imaginative planning, enthusiasm and hard work at the county levels."

Printed materials, television, radio, speeches, meetings, et al, in the communities will deal especially with "an examination of the broad spectrum of medical progress in the past few decades."

AMA President Edward R. Annis, M.D., has declared that "With emphasis on local achievements and local responsibilities, 'Community Health Week' affords the medical society the opportunity to present the viewpoint that existing medical services are the fruits of the community's hard work in earlier years and that it is the responsibility of each citizen, working with his neighbors, to help plan now for tomorrow's need."

A kit from AMA and materials from the Michigan sponsors have been sent to each component county society for implementation.



List Outstanding Speakers For Genesee Diabetes Day

Six men of national reputation have been obtained for the Genesee County Medical Society "Diabetes Day" at Hurley Hospital, Flint, Wednesday, November 6.

Franklin W. Baske, M.D., Chairman for the program, reports that the meeting will be held in cooperation with the Whiting Foundation of Flint.

The six speakers and their topics are Jerome W. Conn., M.D., University of Michigan, "The Differential Diagnosis of Spontaneous Hypoglycemia"; George J. Hamwi, M.D., Ohio State University, "Insulin Resistance and Insulin Antagonists"; Robert C. Hardin, M.D., University of Iowa, "Is Diabetic Angiopathy Prevented or Affected by Therapy?"; Robert L. Jackson, M.D., University of Missouri, "Management of the Infant and Child with Diabetes Mellitus"; Rachiel Levine, M.D., New York Medical College, "Relationship of Experimental to Clinical Diabetes"; and Max Miller, M.D., Western Reserve University, "Mechanism and Use of Oral and Hypoglycemic Agents."



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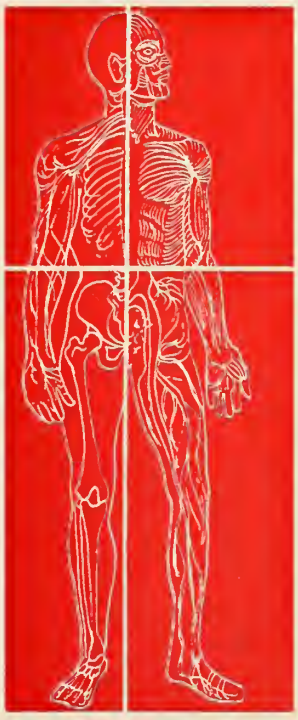
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The Alcoholic in Industry

Harold H. Gay, M.D.
Midland, Michigan

ESTIMATES of the number of alcoholics in the United States vary between 4,000,000 and 6,000,000, or, as sometimes stated, between 2 to 4 per cent of the population. However stated, it is a matter beyond dispute that there are enormous numbers of alcoholics in our American Society.

If we take 60,000,000 as the present work force in the United States, then it is a simple matter to estimate the number of alcoholics in that group. Using 2 per cent as a conservative figure, there must, then, be 1,200,000 alcoholics employed by industry. This is a body of employees who, for many reasons, cannot be ignored. To begin with, the great majority have considerable seniority—they have been in the work force a long time. Usually, they are skilled people, often with indispensable experience and "know how." Indeed, this is the very reason why alcoholism is often spoken of as the hidden disease, because the alcoholic's supervisor is anxious to keep him on his payroll for the "know how" which oftentimes only he can contribute.



The alcoholic is a very difficult person to deal with and enormously difficult to live with. He creates home-wrecking problems for his family, staggering expense for his community, and costly man-hour losses for his employer.

Until not more than 25 years ago, the alcoholic was looked upon and treated by his fellowmen as a weak-willed moral degenerate, bent on his own destruction and indifferent to the suffering he caused his family, the concern he caused his friends and associates and the pitiable spectacle he made of his own life and affairs. He was considered, discussed and treated in emotional terms.

In recent times, thoughtful people throughout the world have begun to consider and discuss the alcoholic in intellectual terms. Hence, those who can look at the problem objectively think and speak of the alcoholic as a sick person and of alcoholism as a disease. A large segment of our population now gives lip-service to this concept.

In the present state of our knowledge, the etiology of alcoholism is unknown. This, however, is actually an academic matter since control of the symptoms of the disease also arrests the pathology and reverses the prognosis, at least for as long as control of symptoms lasts. Thus, from a practical point of view, control of the symptoms of alcoholism, as with some other diseases, notably, convulsive seizures, schizophrenia, and diabetes, et cetera, is tantamount to control of the disease. True enough, no one acquainted with the problems of

From the Dow Chemical Company Medical Department, Midland, Michigan.

alcoholism will be wholly content until the fundamental cause is known rendering the disease susceptible, hopefully, tc cure. Responsible therapists are agreed, however, that continued control of symptoms is a satisfactory solution to the social aspects of the disease.

In the case of the alcoholic, control of symptoms begins and ends with complete sobriety. There are, of course, many methods, techniques and some drugs which are helpful and sometimes necessary to achieve this basic goal. These are not the concern of this discussion.

The fundamentals which are essential to successfully treat the alcoholic are a genuine interest in the problem, an objective attitude toward his behavior, and a real desire to help him back, force him back if necessary, to sobriety. We know that almost anyone with these qualifications and the willingness to accept the status of benign authoritative figure for the alcoholic has an excellent chance to effect an arrest of the symptoms of his disease. Many people may fill this role. Of them all, the family physician is probably in the most favorable position.

Another whom experience has shown to be in a favorable position to effect an arrest of the symptoms in an alcoholic is his employer. Like the family physician, the employer can be objective in his attitudes. He has much to offer the alcoholic who can control his symptoms; a job, and all of the things which go with it. He also has much to gain from having the alcoholic employee returned to productive life.

Hangovers, arrest, traffic violation tickets, lectures, threats of divorce, pleas on the part of family and friends, all of these things can be dealt with by the alcoholic individually, event by event, one at a time, and the pain can be diluted with more alcohol. The objective, impersonal, unemotional threat of loss of a job upon which most of the necessities and the luxuries of life, including alcohol itself, are dependent, however, is something else. It is one of the few things the alcoholic cannot handle piecemeal. Even so, threat of loss of job is often unavailing so far as arrest of symptoms is concerned unless accompanied by a sincere, objective offer of help.

The alcoholic must be extended help only so long as he is demonstrating productive efforts to help himself.

This is the most personal of all diseases and the one disease most under the direct control of the patient himself. Indeed, so true is this that it has been the major obstacle to its acceptance as a disease. Nevertheless, the alcoholic who can alone and unaided effect his own restitution is indeed a rare person. So he must be helped, but the helping process needs to be concerned with the development of strengths and resources within himself which must grow with his progress toward permanent sobriety.

The threat of loss of job and the offer of help must be accompanied by a definite, prearranged, mutually agreed-to plan or program in which the responsibility for living within the confines of the program is placed squarely on the shoulders of the alcoholic. It must be clearly understood that the program begins and progresses on the basic fact of complete sobriety and that any delinquencies in this program which in any way affect his work will be considered as cause for discharge.

Such a program offering help to an alcoholic employee must involve at least two persons—one representing management, one representing the employee. Where the employees are represented by a Union, the Union representative should be, indeed, almost must be from the Union. Techniques of the administration of any program for alcoholism in industry may and do vary. However, there are a few basic facts about the alcoholic which must be taken into account if such a program is to succeed.

1. Almost, if not all, alcoholics have serious financial problems. There should be someone available to help them get their financial affairs straightened out. If this cannot be accomplished, the chances of successful treatment are seriously reduced.

2. Most alcoholics will have an accompanying health problem, the result of poor nutrition, the toxic effects of alcohol, poor sleep pattern, and so on. Often a major forward stride will be made by having the alcoholic hospitalized. Care must be exercised here to see that he is guided into a therapeutic situation where he will be accepted and treated as an ill person —where, in a word, he will be accepted, not rejected. Usually, any insurance company involved will pay hospitalization costs.

There are increasing numbers of hospitals with excellent staffs which devote their entire time to the disease of alcoholism. In addition, there are increasing numbers of communities where hospital and medical personnel willingly accept the alcoholic as a sick person. It should be mandatory that the sick alcoholic be entered as an alcoholic, not under some "cover-up"

diagnosis. The use of this device to secure much-needed help for the alcoholic is mentioned only to be condemned.

Depending upon individual variations, it will be necessary to refer the alcoholic to many community sources. If there is an understanding member of the clergy in the community his help may be inestimable. Most alcoholics will need the services of the Family Service Agency. Alcoholics Anonymous should be involved early in treatment.

In many communities, the spouses of alcoholics have formed groups which function similarly to the parent Alcoholics Anonymous organization. These groups have taken the name Al-anon. Similar groups composed of the children of alcoholics have formed groups known as Al-ateen. Where such groups exist their help may be very useful. Ideally, the alcoholic should be under the constant care of an interested physician. A qualified psychologist and an understanding psychiatrist sould be available for consultation.

The quicker all the necessary sources of help are established, the more likely is successful treatment. It must be early established that this group of therapists or counselors forms a tight fence about the alcoholic. Ground rules, established early and in the alcoholic's presence, must be rigidly adhered to. Any evidence of wavering on the part of any member of the group will almost certainly condemn the whole venture to failure. The alcoholic is an "alibi artist" and he will try every trick in his vast repertory to play one member against the other. If the Union representative displays any sentimental sympathy, he can quickly drive the faltering patient back to the depth of his disease. The same is true of the representative of management, or any other member of the therapeutic group.

Of the various available treatment possibilities, the alcoholic patient must be led to make his own choice. The choice having been made, the employer must then contact the chosen source of help and make definite arrangements for contact between patient and therapist. It will be best if patient and therapist can be brought together in the offices of the industrial counselor and the program laid out in detail. It will often be helpful to have the spouse of the alcoholic present, though this is not always true.

The one rule to be kept constantly in mind in attempting the rehabilitation of an alcoholic is to keep it all simple. Since the alcoholic is a master at deceit and alibi, he has been able for many years to convince himself that others are to blame for his problems. If he can persuade those involved in his rehabilitation to the same conviction just once, the game is lost and the painful process must be started all over again with at least one strike called. The unexpected meeting with an old friend absent for years, a birthday celebration, a New Year's Eve party, the late stop with convivial friends at a tavern—none of these, or the hundreds of other "excuses" must be accepted as condoning the abandonment or interruption of a program of complete sobriety and it must be clearly spelled out in the initial interview that there will be no excuses.

It must never be forgotten, however, that every victim of chronic disease has his relapses. The human will is fallible and where it must be depended upon to maintain a steady state, many will certainly stumble. How many diabetics have never abandoned their diet for ever so brief a time? Such a relapse from a rigid diabetic program can go undetected and unknown to any but the delinquent. How many convulsive seizure victims have not briefly omitted their anti-convulsive drugs with disastrous results? In these two diseases and others as well, a momentary or temporary delinquency is of really minor significance and therapy can be resumed without measureable harm to the over-all management of the disease.

For the alcoholic, however, such a relapse is catastrophic. The first drink marks the complete and final termination of therapy. If it is to be resumed, it must be begun all over again. Usually, he can no more attain a state of sobriety following a fall from therapy than he could the first time and all the resources necessary to bring him to such a state will have to be brought to bear once more. Usually, such a relapse is a hard-earned lesson, but many will relapse several times before the experience can at last bring him to permanent sobriety.

It must never be admitted in the presence of the alcoholic that relapse is possible, or permissible, but it must always be remembered by the counselor that such a fall is almost certain. Armed with these two contradictory attitudes, the alcoholic can be given strength and the needed determination to avoid the pitfalls of his disease and the counselor can reserve to himself the wisdom and the compassion necessary to deal with such a fall.

This must not be allowed to happen too often,

however, and no glib excuses must ever be accepted. Wisdom must be sharp and hard and compassion must be firm and totally impersonal. It must never be forgotten that the alcoholic is by nature, by training, and by experience a master of deceit. No excuse must ever be accepted by word or attitude, because there is no excuse. The hard fact is that this person can never drink again without being plunged immediately into the depths of his original disease. This is the foundation of all therapy and any attitude which does not take this fact into account is certain of failure.

If, finally, this laborious, difficult program appears to have failed and it becomes obvious that the alcoholic is not making an honest effort to effect his own restoration, then the agreed-upon alternative must be used. He must be released. Oftentimes, this final act may be therapeutic, acting as a sort of shock treatment which finally brings the individual to the full realization of the seriousness of his disease. At this point the original team, minus the industrial counselor, may effect an arrest of the disease which the slightly gentler treatment outlined above may have failed to achieve.

If this should occur, then there would appear to be no valid reason why the individual should not be rehired after he has proved his rehabilitation.

Mimae—The Great Impersonator

In 1959, there was an epidemic of penicillin-resistant "gonorrhea" reported in American troops in Korea. Diagnosis of the etiologic agent in this outbreak was made by stained smear alone. This report appeared quite startling in view of the fact that the gonococcus has never developed any resistance to penicillin, either by *in vitro* or *in vivo* experimental trials. Some light may be shed on the problem, however, by an introduction to a noted imitator—*Mimae polymorpha*.

This organism is a short gram negative rod which on direct smear, in various environments, and in young cultures may be indistinguishable from the organisms causing gonorrhea and meningococcal meningitis, which are gram negative diplococci. The clinical importance of this organism has become increasingly apparent in recent years. It has been incriminated in a variety of conditions including fulminating septicemia, subacute bacterial endocarditis, dermatitis, urethritis, and other urinary tract infections, infection of brain substance secondary to head trauma, and meningitis.

The organism not only is able to mimic the gonococcus and meningococcus in smear and young culture but in clinical manifestations as well. When the organisms have been found in cerebrospinal fluid they have been associated with all the symptomatology found in meningococcal meningitis, although some reports have come to light in which prolonged, mild clinical cases have resulted.

The antibiotic therapy of choice for this organism is not penicillin, as is the case with gonococcus and meningococcus. Favorable results have occurred with the use of sulfadiazine in conjunction with the tetracyclines.

There is a moral to this story of Mimae, the great impersonator: When dealing with infectious disease beware of basing an etiologic diagnosis on the results of direct stained smears alone. Definitive cultures should always be performed to corroborate the stained smear.

Clues to the Diagnosis of Alcoholism

Richard C. Bates, M.D.
Lansing, Michigan

IN THE United States at the present time, one adult in twenty is an alcoholic and cirrhosis of the liver is the 10th cause of death. The average physician probably encounters one or two alcoholics in his practice daily but few of us make the diagnosis that often. Yet, next to the traffic judge and the family, we stand in the most favorable position to do so.

Our failure is not surprising when the patient usually does his best to conceal the diagnosis and may be abetted by his family. Undoubtedly some physicians unconsciously avoid diagnosing alcoholism because of an emotional rejection of the alcoholic, feelings of guilt about their own drinking habits or feelings of inadequacy in their ability to treat the disease. Many alcoholics are totally unaware that they suffer from the condition and consider for years that they are merely heavy drinkers who have had a lot of bad luck in life.

Alcoholism *is* a disease—progressive, serious and potentially fatal. In the middle stages it produces a variety of social and physical phenomena that makes the diagnosis a thrilling challenge to test the mettle of those who pride themselves on diagnostic acumen. Yet, all too many physicians are only aware of the signs in the late stages when cirrhosis is imminent, little challenge is present, and even less chance for cure. The analogy of waiting until the appearance of hemoptysis to diagnose TB is obvious.

In the past two years we have had an opportunity to examine over 400 alcoholics from all walks of life admitted to our unit at E. W. Sparrow Hospital. This experience has educated us in picking up clues that sometimes suggest alcoholism in private patients coming to the office for other complaints.

At the start of the examination of a new patient, one's suspicions should be aroused by a sulky, uncooperative male who states his wife nagged him into an examination. Alcoholics as a rule are depressed, tense, self-centered, hypochondriacal, impulsive, hostile and immature. The present illness will usually display many of these traits and the family history may be revealing in that, if your patient is a child or sibling of an alcoholic or cirrhotic patient, he has a 50-50 chance of alcoholism himself.

The past history may occasionally yield the picture of several automobile accidents, a gastric resection for intractable ulcers or pancreatitis. The ulcer patient who admits to regular social drinking is a suspect. Remember that alcoholics have five times as much tuberculosis as the general population, and half the patients in a sanatorium are alcoholics.

Naturally the social history will be most fruitful. You may not wish to take such a full history on every patient, but if the thought of alcoholism enters your mind at any time during an examination, you will be well-advised to inquire into the following:

1. A patient without a high school education: 55 per cent of our patients dropped out of school before getting their high school diploma. This is a sign of immaturity and impulsiveness—two characteristics that cripple the alcoholic for many years. The school gadfly often metamorphoses to a bar fly.
2. The man who changes jobs frequently: a third of our patients have had more than five jobs in the last ten years.
3. The man who holds a position well below his obvious education and ability.
4. The executive in a good position who takes an inferior job with a smaller company.
5. The self-employed man who goes into bankruptcy.
6. The apparently healthy man who is unemployed.

One of our most significant statistics is that two out of three of our male alcoholics are not living with a wife when we first see them, but are bachelors or divorced men living alone or with other men. Only one in five of our patients is still living with his first wife and 10 per cent are bachelors. Roughly half of all divorces are thought to arise from alcoholism. Whenever you hear that two of your patients are divorcing, ask each if the other drinks too much.

A history of excessive cigarette smoking (arbitrarily

placed at more than a pack a day) was present in a little over half of our subjects and this association suggests that careful inquiry into drinking should be made of any heavy smoker, particularly if he has visible tar stains on his fingers, as occurred in about 60 per cent of our patients.

After asking about cigarettes, one should always ask about alcohol habits and take a careful, gently persistent, thorough history until he is satisfied that he knows when, how often, how much and for what reasons his patient drinks. Any hint that he "sometimes" drinks "too much" or "more than I should" or "more than my wife thinks I should" argues strongly for the diagnosis. Any patient who asks if he might be an alcoholic or who says that he sometimes thinks he is an alcoholic is offering the physician a clue in hopes that it will be taken up and discussed. Sometimes the statement will be made in such a way that the physician's instinctive response will be one of reassurance, but if he falls into the trap of telling the alcoholic that he is *not* alcoholic he may do tremendous harm and perpetuate the disease for months and years. We have seen some tragic results where patients have been reassured that they were not alcoholic but neurotic, and that their heavy drinking was only a symptom of tension, thus enabling them to drink with renewed vigor while fending off their wife's protests with an authoritative proclamation from the doctor that it was "all right."

Roughly, a person who admits to eight drinks* in the course of an evening is probably an alcoholic. No absolute limit can be stated since factors of body weight, stomach content, time lapse and liver function all modify the blood alcohol level. It must be remembered that one usually forgets precisely how many drinks he's had after six drinks and most people will shave their estimates by several drinks. After the age of 25, male social drinkers seldom get drunk, women almost never. For normal people, drunkenness is an unpleasant experience and the social drinker can and does avoid it.

When this line of questioning begins to pile up evidence that one is, indeed, dealing with an alcoholic patient he can then ask if the subject has ever been threatened with loss of job or marriage because of drinking or been arrested because of drinking or drunken driving. A positive answer to any of these is virtually conclusive. In our patients from all walks of life, five of six have been arrested at least once and four of six more than once in their lives. Hospitalizations for drinking or bouts of delirium tremens generally indicate the later stages of the disease.

On physical examination, look first for shabbiness, poor hygiene and poverty below a man's position, education and social background. A red face and acne rosacea are familiar signs even to the layman. Alcohol is more vasodilating to the alcoholic than to the social drinker. Periorbital edema, bags under the eyes, scleral edema and nystagmus on lateral gaze all suggest a hangover. Coarse tremor of the outstretched hands occurred in 80 per cent of our patients. Tattoos are seen in one alcoholic in 10, and any tattooed patient must be considered alcoholic until proven otherwise.

If a palpable non-tender liver can't be explained by cholecystitis, diabetes, emphysema or obesity, it strongly suggests alcoholism—55 per cent of our patients had a palpably enlarged liver.

Bruises in unusual spots—other than the thighs and shins—are frequent and come from lurching around the room in a drunken state. Alcohol on the breath need scarcely be mentioned as an important clue. The man who stops on the way to the doctor's office for a drink may be taking alcohol as a tranquilizer.

Women provide a particularly difficult problem in the diagnosis of this disease. The female patient who calls you at home evenings or in the middle of the night and talks endlessly, repeats herself and makes flattering personal remarks is probably drunk. Home accidents, fractures and falls in women under 65 may be the first and only clue to the female alcoholic. Quite suspect is the person who is injured in a home accident but fails to report for medical attention for several hours or days later because she "didn't want to bother you in the middle of the night" or "it didn't hurt at first." In truth, she didn't want you to see her drunk or didn't feel the pain or realize she was injured until the alcohol wore off.

On house calls, you may observe poverty and shabbiness not in keeping with the income level of the breadwinner's job. Working wives often denote drinking husbands. Able-bodied men on relief may be alcoholic, as well as the supposedly well-to-do patient who doesn't pay bills promptly and the man who calls and says he's been off work three days with a "cold" and asks you to fill out a slip so he can return to the job even though you have not seen him in the office.

In the hospital, the patient who becomes critical of his care, agitated and restless and signs out in anger may be having a withdrawal reaction. Increase his

*A drink is 1¼ ounce of 86 proof liquor, 4 ounces of 16 per cent wine or a 12 ounce bottle of beer. A cocktail counts as two drinks.

sedation and he may stay. Persistent unexplained tachycardia is a most important clue. A grand mal convulsion in an adult with no previous history of epilepsy, occurring 24 hours to 48 hours after admission may be a "rum fit." If it occurs from the second to the tenth day, consider barbiturate addiction as well. Unexplained delirium in a hospital patient is usually delirium tremens.

Office patients who call for tranquilizers and sleeping pills at intervals indicating that they are doubling up on the dose you prescribed have addictive tendencies and will probably be found to use alcohol in an uncontrolled fashion, too. Out-patients on anticoagulants whose prothrombin times fluctuate widely may be drinking heavily.

Finally, think of the diagnosis whenever you encounter a situation that puzzles you; where the relatives seem to be holding something back or you have an uncomfortable feeling that you don't fully understand what's going on in a patient's mind and life. Ask the unhappy sulky teen-ager, the depressed premenopausal mother if there is one of these problems in the home. Remember that alcoholic males tend to marry alcoholic females, especially on the second marriage. When you are dealing with one alcoholic partner always inquire into the drinking habits of the other.

Summary

The diagnosis of alcoholism is a constant challenge. Possibly no other common illness is so frequently missed. Yet many clues are present in the usual case. Whether or not a physician is interested in alcoholism, he cannot afford to shut his eyes to a condition that afflicts 5 per cent of our adult population and shortens life expectancy by 15 years. If he makes the diagnosis, a number of sources are available to him for help. In our experience if a patient who has the disease is apprised of the diagnosis and guided to help by an understanding physician he and his family will be eternally grateful and the physician will reap as much self-satisfaction as though he had detected an early cancer. Listed here are many clues, easy to discern, which have proved helpful in the diagnosis at a stage when there is at least a 50 per cent chance for permanent arrest of the disorder.

American Hospital Association Supports Alcoholic Admissions

In spite of the difficulty encountered in gaining hospital admissions for alcoholics, the American Hospital Association's board of trustees passed the following statement in 1957:

"Alcoholism is a serious health problem. It falls within the scope of medical practice and it is often a medical emergency.

"The alcoholic should not be denied the advantage of a thorough study of the cause or causes of his condition and should not be denied the advantage of the best possible management of his case.

"In 1944, a special committee of the American Hospital Association recommended that 'the primary point of attack (on alcoholism) should be through the general hospital. Because of the completeness of its facilities and of its accessibility, it is the logical place to which an alcoholic or his family would turn.

"There are still many hospitals that deny admission to all alcoholic patients despite the availability of improved methods of treatment and demonstration by experience that only a minority of patients with acute alcoholism are uncooperative.

"Such a policy denies to the alcoholic patient benefits which would be available to him were his acute poisoning from another source, such as food, et cetera. It also denies to hospital attending and house staffs opportunities for education in the management of the alcoholic patient.

"The American Hospital Association urges general hospitals to develop a program for the care of alcoholics and, having done so, to base the decision as to admission or non-admission of the patient with a diagnosis of alcoholism upon the condition and needs of the individual patient.

"This progressive step would keep pace with increased recognition of 1. the general hospital as the community health center and 2. alcoholism as a medical problem requiring broad-scale attack if it is to be solved."

Alcoholism: Diagnosis and Long Range Treatment

Melvin L. Selzer, M.D.
Ann Arbor, Michigan

WE ARE fortunate to live in an era in which many heretofore mysterious illnesses have been etiologically illuminated. The etiology of alcoholism, however, remains obscure and is probably diverse and multiple. Indeed, alcoholism is best regarded as a group of diseases with a common dominant symptom: addiction to alcohol. The symptom and its effects are so striking that they tend to overshadow the fact that behind them lurks a human being. This is an important point because alcoholism cannot be treated—one can only treat the alcoholic.

Diagnosis

Surprisingly, most alcoholics are invisible as such, even to their physicians. There are a number of reasons for this[1,2] and only a few of the more significant will be briefly mentioned here. Most alcoholics consult their physicians for reasons other than their alcoholism *per se*! Even when requesting treatment for symptoms caused by their drinking (i.e. malaise, chronic dyspepsia or G.I. bleeding, chronic fatigue), the association may be obscure since most alcoholics deny their alcoholism and will not voluntarily mention it. This denial is not mere lying, but a deep, abiding conviction that their drinking is of no significance.[3] (If a man deceives himself, whom can he not deceive?) Added to the alcoholic's denial is the conviction of some physicians that alcoholism is limited to skid row types. In truth most alcoholics are respected citizens who work regularly, their alcoholism unknown to even their next door neighbors. (When the Consolidated Edison Company of New York established a treatment program for its employees, it was discovered that the 183 alcoholic employees who subsequently underwent treatment averaged 22 years with the company.[4])

Alcoholism is a "variable" addiction when compared to narcotic addiction. The narcotic addict must dose himself every several hours or telltale, agonizing, withdrawal symptoms will appear. The alcoholic may or may not imbibe daily but the quantity of alcohol consumed will vary with such considerations as type of employment, funds, and proximity to the weekend. Many alcoholics will "rest" between binges and use this to convince themselves and the unwary physician that they can "take it or leave it."

A number of alcoholics become and remain alcoholic on beer alone. Hence the statement, "All I drink is beer," does not rule out alcoholic addiction.

Finally, the difficulties in diagnosing alcoholism in women are worth mentioning. It is extremely difficult to elicit the necessary information from or about a woman. Social and economic factors enable the woman alcoholic to cover up her drinking problem more effectively than does her male counterpart. Her family will suffer in silence for decades rather than seek professional help because they are ashamed to reveal "mother is an alcoholic." I suspect another reason for the infrequency of this diagnosis in women is that it is seldom thought of when dealing with the fair sex.

Treatment

The treatment of a patient's alcoholism is not to be confused with the treatment of the complications of his excessive drinking. The former is a more formidable, but potentially more rewarding task. Although there is no single treatment approach that will assuredly work with every alcoholic, a number of techniques are available, each of which will be effective with some members of the alcoholic population.

Psychotherapy and Counselling.—One of the most effective therapies for the alcoholic is individual psychotherapy or counselling. The physician's sincere interest in the patient is itself an effective therapeutic instrument, provided he can remain interested and helpful even when the patient relapses and goes on a binge. The physician must try to understand any feelings of discouragement or anger he may harbor toward

From The University of Michigan Medical Center, Ann Arbor, Michigan.

the alcoholic in order to have the emotional freedom necessary for concentration on the alcoholic's problems.[5] Some workers have even advised that the physician share the responses within himself—even hostile ones—with his alcoholic patient.[6] Presumably this would increase the sense of trust and sharing communicated to the patient, because the alcoholic's feelings of other's perfection and his own relative unworthiness will be reduced. Only by listening and talking to the patient will the physician learn that the alcoholic is a frightened, often depressed, person who feels life without alcohol is the equivalent of a death sentence.

Deep probing into the alcoholic's unconscious psychological processes is usually unnecessary—and is poorly tolerated by most alcoholics. It is more helpful to discuss what the patient himself feels his problems and needs are; this can be done on a practical, common-sense level. If the alcoholic states that his real problem is his wife, his job situation, or his (drinking) companions, the physician should respond: "Let's talk about your wife," rather than argue the point. The patient is thus encouraged to ventilate his feelings to the physician. Ultimately, physician and patient will be able to understand what role the wife, job, and other factors play in the patient's life. Little by little, through the use of relatively brief interviews, the physician can expand his knowledge of the patient—and about certain common aspects of the alcoholic syndrome, always searching for factors in that particular alcoholic's life that make the constant use of alcohol so appealing—and sobriety so appalling.

Since the self-esteem of most alcoholics is low, it is important for the physician to offer encouragement, principally by pointing out and stressing the alcoholic's assets. However, false encouragement uttered without conviction or dependent upon emphasizing assets that do not exist should be avoided; the alcoholic will sense the physician's doubts and feel that his outlook is hopeless.

During his contact with the physician, the alcoholic may repeatedly attempt to convince himself and the physician that alcohol is *not* his real problem. This can sometimes have great appeal for the weary M.D. whose task would indeed be simplified if his patient were not an alcoholic. While discussing various problems in the patient's life, the physician should not permit the alcoholic to conclude that alcohol is a trivial part of the picture. The drinking itself, its past, present, and future consequences, should receive firm emphasis throughout. The alcoholic will strive desperately to remain convinced that he does not really need alcohol (i.e. is not an alcoholic). Only by this mental maneuver can he maintain the fiction that there is really no need for him to give up drinking.[3] Any attempt at denial, however subtle, should be pointed out and discussed. Sobriety is not the only goal in the treatment of the alcoholic but its achievement is crucial for success.

The patient himself should be consulted initially and from time to time to discover what he feels would be helpful in moving him toward recovery. His ideas are often worthy of respect despite the fact he may have been unable to implement them before the physician began to help him. (A simple example comes to mind: I had been treating a professional person for a few months, during which time he remained continuously intoxicated. I asked him if we could do something at least to interrupt his drinking long enough for our sessions to attain some significance. He opined that if he could get away to Florida with his wife for a few weeks, he could perhaps stop. I contacted his wife and his son, both of whom were already working with me, and the trip was arranged. He returned sober and stayed that way for several important weeks.)

Therapeutic Assistants.—If at all possible, the physician should not "go it alone" in treating the alcoholic. The alcoholic's often difficult personality, the tendency toward numerous relapses even when on the road to recovery, and his sporadic need for someone to lean on, make it almost mandatory that the M.D. enlist the services of "therapeutic assistants"—as many as are reasonably available to him in treating each alcoholic. The patient's wife, parents, adult children or other interested friends and relatives should be drawn into the treatment process and encouraged to work closely with the physician. The patient's minister, Alcoholics Anonymous, and social agencies should be utilized if agreeable to the patient. The social agency can provide both psychological support for members of the family and concrete help in making family members aware of other community resources. (Hospitalizing the patient is another way of acquiring therapeutic assistants and will be dealt with in a separate section of this paper.) The "sharing" of therapeutic responsibilities is important because it helps dissipate the feelings of frustration and failure which may be engendered in the physician when the alcoholic relapses. If several "therapists" are involved, none will experience the intense loneliness that the feeling of failure can bring.

Medication.—Chemotherapy for alcoholism can be divided into two broad categories: deterrent agents and tranquilizers.

Most prominent of the deterrent drugs is Antabuse. Anyone taking Antabuse will become quite ill if he ingests alcohol during the ensuing several days. Antabuse appears to retard the metabolism of alcohol at the acetaldehyde stage resulting in toxic aldehyde levels. The patient is usually instructed to take one tablet (500 mgms.) daily for four days; the dose is then reduced to one half tablet daily. The medication is best taken in the morning and the patient should be taught to make it an integral part of his daily routine (i.e. with his morning coffee). Prior to prescribing Antabuse, the physician must describe in detail to the patient what will happen if he ingests alcohol while taking the drug. In five to ten minutes, he will develop a sensation of heat in his face accompanied by intense, lobster-red flushing which also involves the sclerae, upper limbs, and the chest. He will feel a constriction of his neck and irritation of his throat and trachea resulting in coughing. Most disagreeable to the patient is the intense feeling of uneasiness and general malaise. He will become pale, hypotensive, nauseated and may vomit. Many patients also experience dizziness, head pressure, blurred vision, palpitations, air hunger and numbness of the hands and feet. In many ways, Antabuse is the perfect drug but it has one singular drawback: the alcoholic who is consciously or unconsciously determined to drink can always find a rationalization for discontinuing the drug. The stage is then set for the resumption of his pathological drinking. The therapeutic assistant can help ensure that the alcoholic takes his medication daily—at home or at work.

A number of tranquilizers are available as *adjuncts* to the long term treatment of chronic alcoholism. These drugs are much in vogue now and each year another one is vigorously promoted as the answer to alcoholism. Unfortunately, none is specific for alcoholism and none appears more effective than its forerunners. Tranquilizers, however, can play an important supportive role in the treatment of alcoholism, and chlorpromazine, meprobamate, or promazine should be used whenever alcoholic patients indicate that they are suffering anxiety, restlessness or agitation. (One should guard against the possibility of addicting alcoholics to sedative, narcotic or tranquilizing medications.)

Programs which provide *both* counseling and tranquilizing medication for alcoholic patients have reported improved results.[7] In any case, neither Antabuse nor a tranquilizer can be considered adequate treatment for the alcoholic patient. Either or both should be integrated with the personal counseling and attention of the physician as outlined above.

Alcoholics Anonymous

This fellowship can be quite effective with certain alcoholics. Unfortunately, Alcoholics Anonymous is probably successful with but a minority of the total number of alcoholics who contact the organization. Physicians should not make the mistake of referring an alcoholic to A.A. and then forgetting about him. Alcoholics Anonymous should be regarded as an aid to treatment in those cases where the A.A. program is agreeable and meaningful to the patient. Incidentally, it is virtually impossible to forecast which alcoholics will take to the A.A. program, and it does no harm to encourage all alcoholics to try it.

Hospitalization

Most alcoholics never quite acknowledge their drinking difficulties. Even when they realize that they are alcoholic, the addictive and compulsive nature of the illness prevents voluntary abstention. Continued inebriety poses a barrier to meaningful intellectual and emotional contact with the physician and in effect prevents treatment from beginning. Hospitalization for a period of several weeks enables a therapeutic relationship to develop. It also allows the alcoholic to rediscover sobriety and to begin developing mechanisms other than drinking for handling his problems.[8] A few private and state hospitals now have programs for the in-patient alcoholic which can make his stay beneficial in several ways.

Michigan provides for commitment to state mental hospitals for alcoholism. However, the long waiting lists and the reluctance of families to cooperate create difficulties. Family deprivation—and opposition to hospitalization—can be modified through the cooperation of community-based social agencies. If the family provider is to be hospitalized, social agencies can help with associated problems: Are there ways of keeping the mother in the home while providing for the financial needs of the family? If not, how should care for young children in the family be obtained? These and similar problems require the skilled counselling help of persons who can collaborate with the physician. Despite the drawbacks involved, involuntary hospitalization is the treatment of choice when voluntary methods fail.

Summary

Establishing a diagnosis of alcoholism is not usually an easy task. Considerable ingenuity as well as a high level of suspicion are required, since the diagnosis is made primarily from the anamnesis. Misleading factors include the mistaken belief that alcoholism is con-

fined to skid row inhabitants, the alcoholic's ability to disguise his excessive drinking, and his use of the psychological mechanism of denial. The physician's ambivalence about alcoholism may cause him to support the patient's denial; he may fail to ask certain pertinent questions in order to avoid discovering that he is dealing with a syndrome for which he does not have all the answers.

The physician may be deceived by a number of factors, all of which are at times exploited by the alcoholic to demonstrate that he is not alcoholic. Among these is the intermittent addictive need of many alcoholics as contrasted to the more compelling dosage requirement of the narcotic addict, and the fact that one can become and remain alcoholic on beer alone. Although alcoholism is not uncommon in women it is often overlooked because one is not inclined to associate alcoholism with the gentler sex.

Alcoholism is best treated by the general physician. Counselling and the use of the patient's family and friends as "therapeutic assistants" are the backbone of any treatment program. Chemical deterrents (Antabuse) and tranquilizers may be used at the discretion of the physician. Referral to Alcoholics Anonymous may be worthwhile but is not a universal panacea and should not be used as a means of getting rid of the patient. Hospitalization for a period of several weeks is often necessary for the treatment process really to begin.

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Pediatric Views re Competitive Sports

The Fourth National Conference on the Medical Aspects of Sports (sponsored by the AMA) featured a panel on "Pediatric Views on Competitive Sports for Children and Adolescents." Harry F. Dietrich, M.D., of Beverly Hills, who spoke on the subject of Athletics in Adolescence, emphasized that "the participation of school-age children in sports should be accompanied by proper conditioning, careful coaching, good officiating, right equipment and facilities, and adequate medical care. These," he said, "can be insured by careful screening of participants and enlightened supervision."

Dr. Dietrich pointed out that "sympathetic but strict enforcement of scholastic requirements will insure no serious encroachment on scholastic achievement. The enjoyment and satisfaction of sports participation is more closely related to the student's motivation than to his innate ability."

The next National Conference on the Medical Aspects of Sports will be held December 1 at Portland, Oregon, in conjunction with the AMA Clinical Meeting.

Etiology of Chronic Alcoholism

Robert A. Moore, M.D.
Ann Arbor, Michigan

The Problem

AMONG our public health problems, chronic alcoholism today would rate as one of our most serious. Certainly, among our addictive illnesses, the heartache, wasted lives, and financial burden created by this illness far outweigh the others when we realize that approximately five million sufferers are afflicted. Additionally affected are the spouses, parents, children, employers, employees, taxpayers, and innocent auto accident victims. This leads to the inescapable conclusion that we are faced with a national problem approaching calamity proportions.

The comments that follow concern an illness defined as, "a chronic disease manifested by repeated implicative drinking so as to cause injury to the drinker's health or to his social or economic functioning."[1] Most alcoholics seem to fit the addictive pattern of drinking characterized by a gradual onset, development of high tolerance, increasing uneasiness during brief periods of abstinence, and mild to moderate withdrawal symptoms. Lesser numbers seem more "reactive" when a severe stress precipitates a sudden increase in drinking but usually without the above mentioned addictive elements, or "symptomatic" when great alcohol consumption acts as a desperately needed sedative for a mentally ill person.

One would anticipate such a serious public health disturbance would attract the best research and clinical minds to the search for a solution. Unfortunately, this has not been so and, until quite recently, anyone working in this area could expect little thanks for his efforts and was often viewed suspiciously as being an alcoholic himself. As a result, our clinical and research efforts have not been very rewarding. There remains considerable difference of opinion about the etiology of alcoholism, much of it clouded by professional chauvinism and illusory hopes of finding a single specific cause. Following is a brief review of the more widely considered theories and research findings in the fields of physiology and biochemistry, sociology and anthropology, and psychology and psychiatry.

Presented in part at the Joint Meeting of the American Psychiatric Association and the Japanese Society of Psychiatry and Neurology, May 13-18, 1963, Tokyo, Japan.

Doctor Moore is Clinical Director of Training and Research, Ypsilanti State Hospital, and Assistant Professor of Psychiatry, University of Michigan Medical School.

Theories and Research Findings

Physiology and Biochemistry.—Increasing knowledge of the effects of alcohol has led many to believe the basic etiology would be found in this area. Much of the research has been done on laboratory animals and the conclusions assumed to hold true for humans. Research findings have often been contradictory and not reproducible. Since the earlier physiology of an alcoholic is difficult to reconstruct (in contrast to his earlier environmental and psychological experiences) there is a considerable problem in deciding on cause and effect. The crucial question is whether a difference exists between alcoholics and non-alcoholics before the onset of heavy drinking. To quote Kalant in an excellent recent survey, "There is remarkably little worthwhile information on this subject."[2]

Williams has suggested a genetotrophic concept[3,4] where a genetic nutritional factor deficiency leads to increased requirements for certain food elements. Alcohol acts as a quickly metabolized substitute but, by its noxious effects, leads to a greater deficiency. These ideas are based on experimentation with rats showing that nutritional deficiencies appeared to increase consumption, by choice, of an alcohol solution. Hoffer and Osmund[5] believe they have found an absolute or relative deficiency in adrenochrome metabolism with alcohol acting in a substitute fashion. Goldberg[6] discovered hypothyroidism in two-thirds of a group of alcoholics; however, Kalant[2] points out that, while thyroxin leads to a decrease in alcohol consumption in rats and thiouracil to an increase, thyroidectomy has no effect. A possibility of a constitutional hypoadrenal response is also criticized by Kalant[2] because of lack of comparison with other chronically anxious patients,

particularly when one considers the hypothalamic effects on adrenal cortical function.

Effects of alcohol found by certain investigators may suggest the possibility of an etiologic factor and include such findings as: an increase in gamma aminobutyric acid concentration in the brain after alcohol ingestion,[7] depression of the reticular formation by alcohol,[2] exhaustion of the catecholamine secreting system by alcohol,[2] decrease by alcohol of anxiety in laboratory animals,[8] decrease by alcohol of a "resentment factor" and a "tension factor" in the serum of humans,[9] a greater amount of liver alcohol dehydrogenase in mice that prefer alcohol,[10] the capacity of alcohol to return autonomic and endocrine deviations in alcoholics in the direction of normal,[11] and the effect of glutamine in blocking the inhibitory action of alcohol.[12]

Despite uncertain and conflicting findings, there continues to be a considerable belief among physicians other than psychiatrists that alcoholics are biologically different in some constitutional way from non-alcoholics. Probably a considerable segment of the public supports this idea along with a large proportion of the alcoholics who find this a means of reducing guilt over their behavior.

Sociology.—There is increasing interest in comparative studies of drinking habits and rates of alcoholism between cultures and social groups. Not only are there marked differences between various cities and sections of the country, but also between neighborhoods, social classes, religions, and ethnic groups. Since it is a fair assumption that, within the United States, each group has relatively equal access to alcohol, the varying rates must reflect different social attitudes or amounts of internal need for alcohol.

Horton,[13] after studying 56 primitive societies, postulated a high correlation between inebriety and "subsistence anxiety" where alcohol was easily available and substitute outlets were few. Bales[14] suggests three factors in different cultural rates: the "dynamic factor," i.e. the need for adjustment and inner tension in a culture; the "normative orientations," i.e. attitudes toward drinking which lead to an increase or decrease in tension through alcohol use; and "alternative factors," i.e. degree of provision of suitable substitute gratifications. On the other hand, Mowrer and Mowrer[15] emphasize higher alcoholism rates are found where greater social change and disorganization exists. Various authors[16-20] have demonstrated the effects of guilt over drinking, ambivalent or inconsistent attitudes toward drinking, and association of alcohol and religious values on the rates of alcoholism.

Interesting sociological findings include that by Keller and Efron[21] showing, from the 1950 census, that of cities in the U. S. over 100,000 population, alcoholism rates for the 12 largest were twice those of the 12 smallest with large cities in general tending to have higher rates than rural areas. The 1953 World Health Organization estimates showed the U. S. far ahead of the world in rates of alcoholism, trailed in order by France, Sweden, Switzerland, Denmark, Canada, Norway, Chile, Finland, Australia, England, and Italy. A recent study on Yugoslavia by Moore and Wood,[22] however suggests a roughly equal rate to the U. S. there, and informal opinions of recent observers[23,24] suggest this also holds true for the Soviet Union.

Studies of ethnic groups in the U. S. include that by Snyder[25] of drinking by Jews where total abstinence is unusual but so is alcoholism. He postulates the association of alcohol with religious and cultural activities precludes excessive alcohol consumption from tolerance of the conscience. Similarly, Barnett's study of the Cantonese in New York's Chinatown[20] reveals widespread drinking but little alcoholism nor drunkenness since this would be intolerable before the stern eye of the family patriarch. Skolnick[26] found that people of Slavic descent in the U. S. have double the expected incidence of arrests for inebriety, considerably higher than the Irish, and surpassed only by the Negroes. He questions, however, if this is not more related to social class.

Psychology and Psychiatry.—It is often difficult to separate personality traits and behavior patterns that preceded or are the result of alcoholism. A thorough review by Lisansky[27] reveals ambiguous and inconclusive findings using various psychological tests. One study has shown a greater "field dependence"[28] reflecting an interference in the first few years of life in developing proprioceptive and antigravity reflexes and substituting a heightened response to other sensory stimuli. Other studies have demonstrated greater psychopathic deviation on the Minnesota Multiphasic Personality Inventory,[29] and more schizoid traits, ambivalence, latent homosexuality, and dependence in the alcoholic.[30]

Organization

A World Health Organizaiton committee expressed the opinion that alcoholics had no definite personality traits.[31] Lisansky, however, suggests that a few homogeneous traits may combine with a wide variety of heterogenous traits to lead to a homogeneous drinking personality.[27] Zwerling's view[32] would probably be acceptable to most clinicians when he states: "A con-

stellation of traits may well be basic to the etiology of addictive drinking, and yet be embedded in such a diversity of character structures as to be obscured to eyes focused only upon the most dominant integration of the total personality as it is manifested in the clinical diagnosis." He found alcoholics are characteristically schizoid, dependent, angry, depressed, and sexually immature.

Learning theorists have attempted to explain the excessive use of alcohol as it affects the approach-avoidance conflict. Dollard and Miller[33] suggest that alcohol, by reducing fear, decreases avoidance and, thus, reduces the conflict. This leads to a reinforcement of drinking. Conger[34] adds that alcohol, while reducing drive, leads to reinforcement and learning to drink through reward. Ullman[35] sees three necessary conditions for learning to drink excessively: a desire to drink from past experience and social attitudes, a juxtaposition of a stress situation while drinking, and a reduction of tension from the stress by alcohol. Learning theory does not tell us much about the nature of the conflicts, however.

Psychoanalysts have offered explanations for alcoholism and addictions in general that have remained rather consistent over the years. A brief synopsis of major conceptions of this topic include: early conflicted experiences with an under-gratifying mother (occasionally markedly over-gratifying) leading to a replacement of external misery with pleasurable phantasies of infantile oral gratification;[36] regression toward infantile fixations;[37] use of alcohol to relieve pain and tension and to regain the infantile pleasure state;[38] use of alcohol as a proof of love to counter frustrated rage and attendant guilt;[39] as a means of self destruction over guilt caused by this rage;[40] the use of alcohol as a magic fluid that decreases tension and loneliness, provides a sense of mastery, and allows expression of hostility;[41] as a protection against depression resulting from introjection of the disappointing mother and resultant attack on the introject.[42] These theories have been widely criticized because they seem to suggest a homogeneity or unitary factor in alcoholism but this criticism is partly a result of too literal reading and the difficulty of the psychoanalytically untrained person fully to understand this complex field. In addition, there is the earlier mentioned problem of failure to see more subtle homogeneous traits obscured by the more obvious heterogenous personality structure of alcoholics. The concept of latent homosexuality as one of several causal factors has especially aroused antagonism though one recent research effort shows alcoholics fall, on these particular research criteria, midway between overt homosexuals and normals.[43]

Along with an increasingly widespread public acceptance of psychologic phenomena in general, the more sophisticated laity are inclined to assume (without proof) the psychological cause of alcohol addiction. This belief, encouraged by clinical experience, is the prevalent concept held by psychiatrists, psychologists, and social workers. It appears a perceptible shift is occurring among alcoholics themselves, as exemplified by Alcoholics Anonymous, in accepting emotional factors as playing a major role in causation.

An Overview: One Possible Explanation

Since the facts are inadequate to allow us to reach a universally accepted conclusion, we must continue to deal with testable hypotheses. From my own clinical experience (colored by my training and orientation), I would suggest the following broad explanation of how alcoholism develops. It hardly needs stating that many exceptions will be found and that no one person will exactly fit this model.

We start with an infant with all its hereditary potentials, constitutional limitations, and the expectations for behavior of its culture and family with which it immediately comes in contact. In the earliest infant-mother relationship, the infant senses itself as omnipotent in that it has no conception of world or meaning other than its own physical sensations. By using magical gestures such as whimpers and cries, the infant early experiences the receipt of immediate gratification. This sought-for gratification consists of a pleasant sucking activity of the mouth, a satiated feeling in the stomach, a warm dry feeling on the skin surfaces, a pleasant cuddled position, a loss of physical tension, and finally sleep. Rhythmically, a sense of tension or expectation arises and again magical gestures bring forth immediate gratification demonstrating anew the infant's power. Such constant reassurance of omnipotence cannot continue forever and with each failure to achieve this immediate pleasure a sense of frustration or heightened tension results. After enough experiences of disappointment, the infant must reluctantly begin to learn that its omnipotence is not true when its gestures fail to bring immediate gratification. With gradually increasing doses of reality, he is able slowly to renounce such strivings to a considerable degree in favor of delayed, more mature pleasures which bring greater satisfaction in the long run in the form of praise from the mother. Sometimes such a fortunate train of events does not occur without interference. There may be some innate, as

yet unmeasurable, biological variation that makes some developing infants less able to delay their pleasure, give up their omnipotence, and tolerate reasonable levels of physiological tension. In addition, parents being only human too, the dosage of increasing frustration may be administered quickly, in too great amounts, or not soon enough or in large enough amounts. Either may result in lessened ability to delay pleasure, tolerate tension, with the resultant clinging to infantile omnipotent phantasies and magical gestures. The result will be an increasing harsh conflict between the real and phantasied world with growing anger at the ungratifying mother and unwillingness to move towards a love relationship with others which would be similarly too disappointing to tolerate. Relationships with others, then, may place a greater emphasis on obtaining selfish gratification with as little payment as possible as contrasted with a more mature relationship to others where the pleasures and life of the other is nearer to being equal with the pleasures and life of one's self. Increasingly, other people are viewed as "givers of supplies," important and to be played up to as long as they deliver, but to be turned on with rage and driven away when they ultimately fail.

Returning to this infantile state, to be full and satiated means proof of omnipotence, leads to high self esteem, and absence of physiological tension. To be hungry means to be increasingly tense and, if prolonged, means a threat to the sense of omnipotence and a resultant feeling of low self esteem. Depression develops. Relief will come from gratification and increasingly is more desperately sought. This state of low self esteem, prolonged tension, and bouts of depression may become a way of life with a chronically unsatisfied person. Too much of his psychic energies are tied up in constant pleasure-seeking activity in an attempt to relieve himself of this painful state.

Whether addictive behavior begins at a young or later age may depend on a number of factors beyond the control of the person. For example, he may achieve enough satisfaction to prevent his turning to addictive behavior during adolescence or early adulthood. The individual with considerable scholastic, athletic, or social capacities may achieve pleasure in more socially acceptable and healthy ways. On the other hand, if he has little else to rely upon, he may have to turn to addictive behavior at an early age, this being especially true of the individual from markedly deprived neighborhoods and families, the individual with low job skills or intellectual capacities. or the one who experiences severe stresses as a youth. The degree of desperateness for an addictive solution may have something to do with the type of addiction, with heroin addiction at one extreme end and the mild addictive activities of everyday living at the other end.

The most usual picture is a gradual onset of addictive behavior as a reaction to the everyday frustrations of living. This gradual onset may be hastened by sudden stresses such as job losses, business failures, loss through death of important figures, separation in marriage, and sometimes even too much success which carries with it the threat of too much responsibility. Continuing to employ the personality traits learned as a small child, the potential addict turns to his or her spouse with increasing demands for satiation and reassurance of worth. This may reach the point where the spouse can no longer tolerate the demands and begins to withdraw. The addictive person, enraged by again experiencing a repeat of the earliest frustrations, responds with rage and drives the unlucky "giver of supplies" further away, thus creating a cycle.

Still, we have not explained alcoholism. Again we must wonder about some physiological predisposition. After all, with this same general background, we can see the roots of many types of addictive and maladaptive behavior patterns. For this individual, it may be that this physiological receptivity for alcohol allows a greater relief from immediate tensions and a greater return to early infantile pleasure states. It is possible that another person could achieve this same solution only through a more potent addicting drug such as heroin, whereas another might find adequate relief from cigarettes, coffee, excessive indulgence in hobbies or religious activities, or almost any kind of activity that gives a person pleasure, reduces tension, and acts to salve a bad conscience. This physiological predisposition, if it exists, still eludes our description. Perhaps, a more important factor is the social climate in which the person lives. It may be, given an equal propensity for alcoholic addiction, that one cultural group will allow the person to move towards alcoholism whereas belonging in another group may make it more likely that the person will turn to narcotics (as is true in oriental countries) or to more socially acceptable and less destructive addictive substitutes. As described earlier, the social attitudes towards alcohol may be very important at this juncture, especially the sanctions of drinking as a solution on the one hand or the arousal of great anxiety over drinking because of conflicted feelings in the community on the other hand. Availability of alcohol or other substitutes in the culture may be crucial factors, too.

Alcohol is an ideal substance to solve the problems outlined above. It is a warming and sedating solution resulting first in a heightened responsiveness with early inhibition of the ascending reticular system, then later increasing sleepiness as the cortex itself is depressed. Heightened self esteem and increased sociability occur and an increasingly rosy glow results. Later, of course, the self-destructive and humiliating aspects of alcohol excess will occur but at this point of pleasure seeking, these things are not considered. For the person who needs to become euphoric, bolster a low self esteem, counter chronic depression, and reduce constant and extreme tension, alcohol has few rivals in efficiency.

From this possible model, we see that any attempt to find a unitary cause of alcoholism seems inadequate and unlikely to be satisfactory clinically. To say that this is a physiological, or a psychological, or a sociological problem is to reveal a lack of understanding of the nature of alcoholism. Alcoholism is a disturbance of the whole person, a form of maladaptive functioning, which is not wished for by the person but gradually imposed on him through years of increasingly unhappy living experience.

Summary

The theories and research findings in the areas of physiology and biochemistry, sociology and anthropology, and psychology and psychiatry are reviewed. As yet, no concise statement can be made as to the etiology of chronic alcoholism and any attempt at establishing a unitary factor explanation seems doomed to failure. Most likely, a person arrives in this world with an as yet undefined constitutional vulnerability, faces early painful disappointments to which he reacts through a lifetime with chronic anticipation of repeated disappointment, high tension, and internalized rage, and then learns through cultural definition the solutions that are available to him. Faced with cultural conflict over alcohol use, the availability of alcohol, and a lack of substitute solutions, he gradually "solves" his internal stress with alcohol, a substance ideally suited for this function. (For a good review of present findings and opinions, see references 2, 10, 18, 27, 44, 45, and 46.)

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If Medicine Is To Remain Free . . .

"If medicine is to remain free, we must cultivate freedom of the individual by discharging our responsibility as citizens and as members of county societies. We must search out and meet the health needs of the community and satisfy the public appetite for health information. Recently, at a meeting of the newly chartered North Carolina Association of Professions, Dr. Martin Black, professor of accounting at Duke University, discussed the qualifications of a profession. Significant among these was that 'The work of a profession is performed in the public interest.' It has been said that success is not an objective but a journey. Just as the end of the rainbow is inaccessible, we may not attain our goals, but it is our firm resolve to pass a few markers, traveling in the right direction. I suggest that we pitch our efforts on the theme, 'Medicine Leads.' Let us lead with good will and with bold intent to search out the truth."—JOHN S. RHODES, M.D., President, North Carolina Medical Society.

Liver Function in Alcoholism

R. Roderic Abbott, M.D.
Flint, Michigan
John L. Conboy, M.D.
Albert C. Rekate, M.D.
Buffalo, New York

As NEWER liver function tests have become available, they have been used to attempt an evaluation of liver function in the alcoholic state. In this paper, the results of transaminase determinations (SGOT and SGPT) are compared with the older more established sensitive tests of liver function. An attempt is made to establish a pattern of intensity and duration of liver abnormality.

Relatively few clinical studies of hepatic function in the acute alcoholic state are reported in the English literature. An early report[1] demonstrated abnormalities in the indirect Van den Bergh and urinary urobilinogen in acute alcoholics; however, selection of patients and associated clinical findings were not well defined. Acute alcoholism was reported to have an adverse effect on the levulose tolerance test,[2] but in a later well regulated study this could not be confirmed.[3] Cates studied BSP dye retention in acute alcoholics and found abnormalities in a significant number.[4,5] The importance of the BSP dye test as a reflection of the effect of the acute alcoholic state on liver function was emphasized in 1949 by Voegtlin et al,[6,7,8] who studied a large number of alcoholics and found this to be the most sensitive indicator of hepatic damage of the tests available at that time. This was subsequently confirmed.[9] The thymol turbidity and the cephalin flocculation tests were also evaluated by Voegtlin in his large series[6] and were found to be "so rarely positive that abnormalities were a curiosity."

In a study of the liver in acute alcoholism, Bang[10] utilized the thymol turbidity, icteric index, serum proteins, and the serum glutamic oxalacetic transaminase (SGOT). A thorough study of the SGOT in alcoholism has not appeared elsewhere in the literature. There are no studies incorporating the closely related serum glutamic pyruvic transaminase (SGPT). In a study of the acute drinking episode in "skid-row" alcoholics, liver function was evaluated by utilizing the BSP dye retention test, alkaline phosphatase, and serum and urine bilirubin.[11]

Materials and Methods

The subjects of this study were 104 consecutive persons admitted for the treatment of acute alcoholism. Chronic alcoholism was a cuncurrent diagnosis in all of these cases. These chronic alcoholics presented acutely intoxicated, having consumed large amounts of alcohol daily for periods varying from a week to several months to the exclusion of an adequate diet.

The size of the liver was assessed on admission and was followed through the hospital course. Although correlation of liver biopsy with enzyme studies in hepatic disease has been attempted,[12] liver biopsy was not done in this series. Early in the hospital course of acute alcoholism needle biopsy is dangerous and if done later would not reflect the early acute changes under study.

SGOT and SGPT determinations were done colorimetrically according to the method of Reitman and Frankel.[13] This method was used on 38 healthy controls (hospital personnel) with a range of 8-28 Sigma units (Su) for the SGOT and 5-20 Su for the SGPT. It was noted that the values were influenced by the environmental temperature at which the color reaction was performed, and 25° C was found to be optimal. Although it has not been generally emphasized in

From the Department of Medicine, Edward J. Meyer Memorial Hospital, Buffalo, New York, and the University of Buffalo, School of Medicine, Buffalo, New York; and the Department of Medicine, Hurley Hospital, Flint, Michigan.

Doctor Abbott is Director, Medical Education and Research, Hurley Hospital, Flint, Michigan. He was formerly Instructor in Medicine, University of Buffalo, School of Medicine, Buffalo, New York.

Doctor Conboy is Assistant in Medicine, University of Buffalo, School of Medicine, Buffalo, New York.

Doctor Rekate is Associate Director of Medicine, Edward J. Meyer Memorial Hospital, Buffalo, New York; Assistant Professor of Medicine, University of Buffalo, School of Medicine, Buffalo, New York.

literature, this has been pointed out and its importance stressed by Pyrse-Davies and Wilkinson.[14] All of our color determinations were carried out at 25° C. Serums were tested on each of the first three days and subsequently were closely followed. The upper limits or normal for SGOT and SGPT were 40 Sigma units and 35 Sigma units respectively.

The conventional tests of liver function which were used were: The Bromsulphalein dye retention test, normal less than 5 per cent retention in 45 minutes,[15] the serum alkaline phosphatase,[16] serum proteins,[17] serum prothrombin activity[18] and the serum bilirubin.[19]

Treatment for acute alcoholism consisted of sedation with promazine and paraldehyde and in many cases chloral hydrate as the former drugs were tapered. Hydration, a nutritious diet, and vitamin therapy including pyridoxine were instituted. Careful attention was given to electrolyte balance and to the detection of intercurrent infections by bacterial examination of blood, sputum, and urine as indicated. Appropriate antibiotics were used.

In this series, one patient was known to have surreptitiously ingested alcohol while in the hospital and after the transaminase activities had returned to normal. A sharp rise in the transaminase activities was noted following his indiscretion. A similar rise was seen in the transaminase activities in a patient who was readmitted acutely intoxicated less than twenty-four hours after being discharged following the return of his abnormal liver function to normal. Because of this apparent effect of short term alcohol ingestion on the transaminase activity in these two instances, as well as the related report of Bang et al,[10] it was decided to attempt to reproduce this experimentally in seven additional cases utilizing not only transaminases but also the BSP and the alkaline phosphatase. Within two or three days after all liver function tests were normal, 150 cc of 95 per cent alcohol was administered in 500 cc of water by a continuous naso-gastric drip over a two hour period. Transaminases were drawn serially and the BSP and the alkaline phosphatase were done sixteen hours after alcohol ingestion and were repeated for several days.

Results

In this series of 104 patients, 85 cases (81 per cent) had at least one abnormal liver function test.

The SGOT activity was abnormally elevated in 77 cases, of which 13 were normal on admission and became elevated within 24 to 48 hours. The peak SGOT activity was over 100 Sigma units (Su) in 27 cases, the highest of which was 1075 Su. Although the duration of the abnormal SGOT activity was generally a function of its degree of elevation in this series, this was not entirely consistent. An example

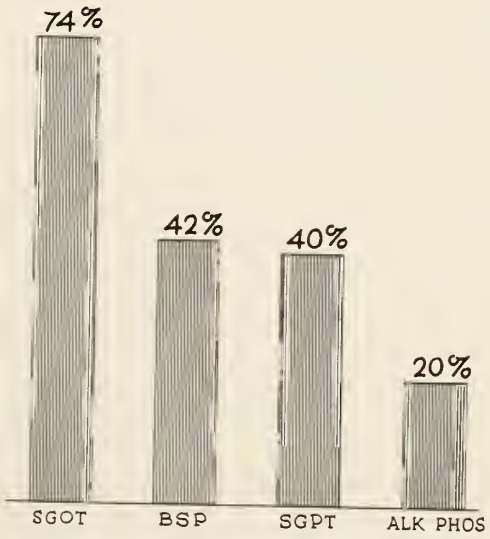


Fig. 1. Percentage of total abnormalities in the four most sensitive tests of liver function.

of a rapid fall of an initially high SGOT activity was the return to normal within eight days of an initial SGOT of 575 Su. In general the duration of the altered SGOT activity was short-lived with over 42 per cent of the elevations returning to normal within four days and over 77 per cent within eight days. Three of the cases with peaks over 100 Su fell to normal within five days, simulating the curve of SGOT activity in myocardial infarction. The SGOT was the only abnormal liver function test in 15 cases and the SGOT and the SGPT were the only two abnormal tests in 10 additional cases. The transaminase tests were both elevated in 42 cases, while the SGOT activity was elevated in 34 cases where the SGPT was normal.

The SGPT activity was abnormally elevated in 42 cases, of which 24 were normal on admission and became elevated subsequently, many times as late as the fourth or fifth day. This delayed rise occurred in 60 per cent of the SGPT elevations as compared with 17 per cent of the SGOT elevations. The SGPT was in no instance the only abnormal test of hepatic function and was never elevated in the presence of normal SGOT activity. In only two cases was the peak of the SGPT activity higher than that of the SGOT. The SGPT activity attained a peak of over 100 Su

in only seven cases as contrasted to 27 such elevations occurring in SGOT activity.

In seven patients to whom alcohol was experimentally administered after the return of all of the initial liver function tests to normal, there was no deterioration in any of the parameters of liver function tested.

In two cases, there was a concomitant diagnosis of bronchopneumonia, and in one case each a diagnosis of congestive heart failure, cardiac arrthymia, long bone fracture, and extensive ecchymosis was made. The above conditions have been reported to be associated with transient elevations in one or both transaminases.[20-26,30] In these cases, the transaminases were elevated together with at least one other liver function test.

The BSP retention was abnormal in 43 of 102 cases tested. The BSP was withheld in two jaundiced patients. In four cases, the BSP was the only abnormal liver function test and was rarely abnormal in the presence of normal SGOT activity (five cases). In 35 patients with abnormal SGOT activity, the BSP retention was normal. Prolonged abnormality of the test was relatively infrequent in this series of cases, 45 per cent of the patients having returned to normal within the first four days and an additional 23 per cent returning to normal by the end of the eighth hospital day. Eighty-six per cent of the patients had normal BSP tests by the sixteenth hospital day.

The alkaline phosphatase was elevated in 21 cases, in one of which it was the only abnormal test. The serum bilirubin was abnormally elevated in only two cases. There was no evidence of hemolysis in these patients.

The prothrombin time (determined in 101 cases) was abnormal in seven. In no case was the prothrombin time the only abnormal test nor was it abnormal in any instance when the SGOT and the SGPT activities were normal.

Serum globulin was determined in 99 cases, of which 18 were abnormally elevated and in the absence of any other apparent cause of hyperglobulinemia were believed to reflect chronic liver disease. The serum globulins were normal in 58 cases in which the SGOT or the SGPT activities were abnormal.

The incidence of hepatomegaly on admission physical examination was 73 cases (70 per cent). Hepatomegaly was associated with elevated transaminases in 55 cases, abnormal BSP retention in 36 cases, and with abnormal alkaline phosphatase activity in 18 cases. Eight of the patients with hepatomegaly had entirely normal liver function. Forty of the enlarged livers became nonpalpable and 20 others definitely decreased in size while under observation. In no instance did the liver become further enlarged during the hospital stay.

Discussion

Since treatment was begun immediately on admission, often some hours before blood was drawn for performance of liver function tests, the effect of our therapeutic agents upon liver function must be considered. In all cases, promazine and paraldehyde were used and in many chloral hydrate was later substituted as a hypnotic. Salicylates were employed as analgesics in cases of trauma and occasionally codeine was necessary.

Korn et al[27] studied 201 patients on promazine, many on massive and prolonged daily doses. In their series, none developed jaundice and 82 patients followed with serial liver function tests showed no worsening of function in any case. This included 35 cases in which SGOT determinations were done and a few in which the SGPT activity was examined. Our series represents another 85 patients with liver dysfunction, all of whom improved while on promazine. Two cases are reported[28,29] in which promazine is implicated in liver dysfunction; however, in both cases there had been recent chlorpromazine administration. The cause and effect relationship in these cases is not clear enough to establish promazine as a hepato-toxic agent by itself. The effect of paraldehyde on the liver is not well delineated. According to Goodman and Gilman,[30] it is not known whether paraldehyde can cause liver damage or aggravate existing liver injury. That paraldehyde may have impaired liver function in this series is unlikely since this drug in many cases was continued in substantial doses for varying periods of time after the liver function tests had returned to normal. Chloral hydrate was begun late in the course of most cases and no deterioration of liver function was noted. Salicylate therapy has been related to alterations of both the SGOT and the SGPT activity,[31] however, in non-rheumatic adults receiving 4 to 6 grams per day for more than a week no alterations were found. In children treated with from 0.6 to 1 gram per 15 pounds of body weight significant elevation of SGOT and SGPT activity has been noted,[31] however, Massie[32] stated that increased SGOT activity did not occur in patients under treatment with salicylates without active carditis being present.

Foulk and Fleischer[33] found elevations of serum

TABLE I. DURATION OF ABNORMAL LIVER FUNCTION IN 104 ACUTE ALCOHOLICS ON TREATMENT

Days	1-4	5-8	9-16	17-20
SGOT	42.6%	77.8%	91%	97%
SGPT	53.5%	78.5%	89.2%	89.2%
BSP	45.4%	68.1%	86.3%	95.5%
ALK PHOS	38.8%	66.6%	83.2%	94.5%

The figures in the table refer to the per cent of abnormal tests which had returned to normal within the given hospital days.

transaminase activity in six of 16 patients with biliary tract disease after the administration of 2 grains of codeine intramuscularly, however, Pyrse-Davies[14] in 10 comparable cases was unable to confirm these findings after the administration of either morphine or codeine. There is no evidence that codeine affects the transaminases in the absence of biliary tract disease.

In this series the incidence of elevated SGOT activity was 73 per cent which compares with the 80 per cent reported by Bang et al.[10] In keeping with the latter series, many of our cases of elevated SGOT activity rose from an initial high normal or low abnormal range to a peak on the third or fourth hospital day. The incidence of the delayed rise from an initial normal level was more remarkable in the SGPT determinations where there was an incidence of 60 per cent compared to 17 per cent of the abnormal SGOT activity. The significance of the delayed rise of these tests is not apparent except to emphasize the importance of serial determinations rather than a single admission test in evaluating liver dysfunction in the acute alcoholic state. It is improbable that the responsibility for the delayed rise is due to the medications employed, e.g., promazine, paraldehyde, because in all cases liver function rapidly improved despite continuation of these drugs. Also Bang et al,[10] who did not use these drugs, observed the same phenomenon.

As is illustrated in Table I, the acute alcoholic episode in the chronic alcoholic is associated with transient liver damage which by presently available measurements regresses on treatment in over 90 per cent of cases by the end of three weeks. The SGOT activity was normal in over 90 per cent of cases by the end of 16 days. In fact, the rapid return to normal of the four most sensitive tests in this study is reflected by the fourth hospital day when approximately 40 per cent had returned to normal. Although there was a sharp contrast in the incidence of abnormality of these four most sensitive tests, there was a close parallel in duration of abnormality.

There have been allusions to the association of elevated transaminase activities to Laennec's cirrhosis.[23,24,34-38] There are few detailed case reports and

TABLE II. LIVER FUNCTION TESTS

SGOT		
Total number of cases studied	104	
Total number elevated	77	(74%)
elevated on admission	64	
beginning after admission	13	
SGOT higher than 100 Su	27	
SGOT only abnormal test	15	
SGPT		
Total number of cases studied	104	
Total number elevated	42	(40%)
elevated on admission	18	
beginning after admission	24	
SGPT higher than 100 Su	7	
SGPT only abnormal test	0	
SGPT elevated with normal SGOT	0	
SGPT peak higher than SGOT	2	
BSP		
Total number of cases studied	102	
Total number elevated	43	(42%)
BSP only abnormal test	4	
BSP elevated with normal SGOT and SGPT activity	5	
ALKALINE PHOSPHATASE		
Total number cases	104	
Total number elevated	21	(20%)
Alk. phos. only abnormal test	1	
Alk. phos. elevated with normal SGOT and SGPT	1	
PROTHROMBIN TIME		
Total number of cases studied	101	
Total number elevated	7	(7%)
Prothrombin time only abnormal test	0	
Prothrombin time elevated with normal SGOT and SGPT	0	
SERUM GLOBULIN		
Total number of cases studied	99	
Total number elevated	18	(18%)
Serum globulin only abnormal test	2	
Serum globulin elevated with normal SGOT and SGPT	3	
Serum globulin normal with abnormal SGOT and SGPT	58	
TOTAL		
Total number cases	104	
Number with at least one abnormal liver function test	85	
INCIDENCE OF HEPATOMEGALY IN 104 CASES		
Hepatomegaly on admission	73	
Hepatomegaly with all liver function tests normal	8	
Hepatomegaly with normal SGOT and SGPT	18	
Hepatomegaly with abnormal SGOT and SGPT	55	
Hepatomegaly with normal BSP	37	
Hepatomegaly with abnormal BSP	36	
Hepatomegaly with abnormal alkaline phosphatase	18	
Hepatomegaly with abnormal globulins	12	

the relationship to acute alcoholic episodes is not made clear. Had there been a recent period of acute alcoholism, especially within three weeks, any transaminase abnormality described could have been on this basis.

The signs and symptoms of diseases occurring concomitantly with acute alcoholism are frequently obscured by this state. Important among these is myocardial infarction. The usefulness of the SGOT in the diagnosis of myocardial infarction is well established.[39,40] It can be seen from our results that 40 per cent of the elevated transaminases (SGOT) fell to normal levels within four days, many times simulating the SGOT curve occurring after acute myocardial infarction. Especially important are the 18 per cent of cases in which there were no other associated liver function abnormalities. In these cases, electrocardiographic examination is important. This was done

in our series with no evidence of significant abnormality.

There has been no previous study reported of the SGPT in acute alcoholism. The incidence of elevated SGPT activity in this series was 40 per cent, the majority of these being delayed rises as discussed above. In only two cases was the peak of the SGPT activity higher than that of the SGOT and in those cases only slightly. In no case with elevated SGPT activity was the SGOT activity normal. That the SGOT attains higher levels than the SGPT in this condition might well be related to the fact that the hepatic concentration of GOT is three times that of GPT.[14,37,41,42] There is disagreement concerning the inter-relationship of the serum transaminases in liver cell disease.[14,37,41,42,46,47]

Until recently, the BSP test was considered to be generally the most sensitive test of hepatic dysfunction. Cates[5] and later Voegtlin et al[6] concluded this from their studies of liver function in alcoholism. Interestingly, only 23 of 455 skid-row alcoholics showed elevations after acute drinking episodes.[11] The 42 per cent incidence of BSP dye retention in our series is somewhat higher than the 24 per cent found in the series of Cates and Voegtlin et al. The significance of these differences is not apparent but may be related to the fact that the BSP test was done promptly upon admission and followed serially in our series. This study confirms the fact that with the exception of the SGOT activity, the BSP is the most sensitive test of liver function in alcoholism. We were impressed by the general rapidity with which the BSP returned to normal from substantial elevations.

With the exception of one case in which the alkaline phosphatase was the only abnormal liver function test, this parameter of hepatic function was of lesser value in demonstrating the disordered state of the liver in acute alcoholism. Generally, the duration of elevation was similar to that seen with the BSP and transaminases activities. In contrast to Voegtlin's series,[6] the incidence of abnormal prothrombin times in this series was low. In two of the seven cases with prolonged prothrombin times, gastrointestinal bleeding was present and may have influenced the prothrombin time as has been pointed out by Cantarow.[43]

A most interesting and important observation was the frequent complete return to normal liver size in instances of marked hepatomegaly under treatment. All enlarged livers became smaller in size with treatment and in those cases in which the liver did not return entirely to normal size or in those lost to follow-up, there were no instances of further enlargement. This is in keeping with the generally held concept of an early reversible fatty stage of nutritional liver disease. Leevy et al[44] have shown histologic regression of fatty liver in six weeks. Fatty nutritional liver disease in malnourished children was studied by Waterlow and Patrick[45] by tissue enzyme assays on serial needle biopsy specimens. In a provocative paper, they described elevated transaminase and malic dehydrogenase levels in fatty liver tissue in 11 of 14 cases which disappeared following treatment. A subsequent experiment has shown similar elevation of GOT in livers of rats starved after prolonged exposure to alcohol. Interestingly, the GPT content was diminished.[48] Further work in this area may elucidate some of the pathophysiological mechanisms operating in nutritional liver disease.

Although no liver biopsies were carried out, as explained above, in our series the clinical features of these 104 patients paralleled 117 patients with fatty livers reported by Leevy.[49] Hepatomegaly was present in 75 per cent of Leevy's series as compared to 73 per cent in our series. Hepatic pain was present in 90 per cent of patients with enlarged livers and was the second most common clinical feature of fatty liver in Leevy's experience.

Laboratory abnormalities differed in this series from those reported by Leevy. The biochemical disturbance most commonly found by Leevy was alteration in total quantity or composition of serum proteins with diminished albumin and elevated globulin levels. In this series, alteration of SGO-transaminase was the most common biochemical abnormality, while in Leevy's report the transaminase was usually normal. We believe that detectable abnormalities of liver function are directly related to the time liver function is studied in the course of the hepatic disease which is under observation. Leevy did not mention when liver biopsy was performed or liver function tests were studied in his series in relation to the admission of the patient. In our series had one waited four days before doing liver function studies, 40 per cent of the abnormalities would have been missed.

It was noted that the SGOT became markedly elevated in an individual who became intoxicated during a 24-hour discharge from the hospital and in another case who secretly became intoxicated in the hospital. In both cases, the liver function tests had recently returned to normal following prolonged alcoholic bouts. However, we were unable to reproduce the results of Bang et al[10] of controlled alcohol ingestion, in which a single patient twice given an in-

toxicating dose of alcohol and followed by SGOT levels, showed a sharp peak on each occasion. Using similar amounts of alcohol in seven patients in whom liver function had recently returned to normal following the acute alcoholic state, we were unable to demonstrate any alteration in the SGOT, SGPT, BSP, and the alkaline phosphatase.

The results of this study have shown that in chronic alcoholics a period of acute alcoholism, certainly in excess of a single intoxicating dose, associated with poor diet, is followed by a transient episode of deranged liver function and frequently by tender hepatomegaly. The dysfunction is reflected most consistently by SGOT elevation and is characterized by return, on treatment, of the altered liver function tests in 95 per cent of the cases to normal within 21 days with regression of liver size. If the SGOT test alone had been employed, only eight of the 85 cases with altered hepatic function would have gone undetected. This is superior to any of the other standard liver function tests or combinations employed and could replace other recommended screening procedures for liver dysfunction in this state.

Summary

1. One hundred and four consecutive cases of acute alcoholism in chronic alcoholics were studied by means of clinical and laboratory methods including the SGOT and SGPT activities, BSP, alkaline phosphatase, total proteins and A/G ratio, prothrombin time, and serum bilirubin. SGPT has not been previously reported in this state.

2. Eighty-five of the 104 cases demonstrated at least one abnormal parameter of liver function.

3. The SGOT appears to be the most valuable indicator of abnormal hepatic function. In only eight of the 85 cases with disordered liver function was the SGOT normal. The importance of serial determinations of SGOT activity is stressed.

4. The SGPT activity was found to be no more reliable than the BSP retention and considerably less valuable than the SGOT activity.

5. The liver dysfunction on treatment is characterized by return of the altered liver function tests in 95 per cent of the cases to normal within twenty-one days.

6. Hepatomegaly was present in 70 per cent of cases and regressed with treatment in 60 cases. In 13 cases, the liver did not change in size. A high degree of association was found between altered hepatic function and hepatomegaly.

7. There was no deterioration in liver function in 104 alcoholics treated with promazine and paraldehyde.

8. Single intoxicating doses of alcohol were fed to seven chronic alcoholics whose liver function had recovered from the effects of acute alcoholism, and in no instance was there deterioration in any parameter of hepatic function.

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Hurley Hospital
Flint, Michigan

Commitment for Alcoholism

Ralph Daniel, M.S.W.

"ALCOHOLISM" means different things to different physicians. There are several attempts to define alcoholism, but the present lack of agreement about the etiology of alcoholism makes definition difficult.* For the purposes of this paper, "alcoholism" means the broad aspects of the illness including both the physical results and the causes of the excessive drinking that characterize the disease.

Acute intoxication and other physical disorders are certainly a vital part of alcoholism, but the treatment of these results of excessive drinking is seldom effective in the care of alcoholics if there is no treatment of the things that cause the excessive drinking. The physician who wants to detoxify his patient will generally find that the facilities of the local general hospital are adequate. Some general hospitals may still be reluctant to accept acutely intoxicated patients, but few hospital administrators would refuse to accept such a patient if the medical staff member insisted.

Intoxication and other physical complications and discomforts are frequently the only problem that the patient recognizes. Many alcoholics believe that they drink like other people only sometimes they just drink a little too much. The physician knows that the "drinking too much" is as much a part of the illness as is the intoxication and he must use the problem the patient does recognize as a first step toward getting him to realize that the real problem existed before he became intoxicated. In past years, physicians were ineffective in treating alcoholics because the physician also saw intoxication and physical complications as the major problem. Once the physician of yesterday got his patient on his feet physically he would dismiss him with the warning to cut down on his drinking. The treatment for intoxication was successful. The alcoholism was untreated. The real change that has come with the recognition of alcoholism as a disease in itself is the concentration on the causes of the excessive drinking instead of the results.

Many physicians in private practice see themselves as the initial alcoholism therapists who manage the physical aspects of treatment and call in Alcoholics Anonymous, alcoholism counselling centers, or clergymen to handle the time-consuming job of the long-range treatment. This treatment transfer will become more and more productive as alcoholism becomes better understood and as early diagnosis, acceptance, and treatment becomes more prevalent. In the meantime, there is a need to think in terms of a more-or-less authoritarian approach that places pressures on the individual and forces him into total treatment. This is the place for commitment. The alcoholic who has a strong desire to quit drinking can get adequate help without commitment. Commitment is a means of helping an alcoholic to want treatment. Many times, the easy availability of alcohol makes drinking a substitute for treatment and the patient must be put in a place where he will not drink.

The terms voluntary and involuntary commitment are misleading. Alcohol meets many needs for the alcoholic and he doesn't want to give up these advantages. He wants the positive results without the negative results of excessive drinking. He is ready for help only when the negative results force him to get help. Regardless of whether he asks for commitment or it is forced on him from outside, he is under duress.

Involuntary Commitment

The laws relating to involuntary hospitalization for alcoholism predate the 1951 act which defined alcoholism as an illness. The laws classify alcohol addicts and chronic inebriates both as offenders and as mentally ill and they permit either punishment by fines or jail sentences or treatment in mental hospitals.

Involuntary commitment to a state mental hospital is handled in a manner similar to the method used for mentally ill patients. A petition is filed in probate court by a member of the family or, at the discretion of the

Mr. Daniel is Executive Director, Michigan State Board of Alcoholism.

*Keller and Seeley, in the University of Toronto Press publication, *The Alcohol Language*, define alcoholism as "a chronic disease or disorder of behavior characterized by the repeated drinking of alcoholic beverages to an extent that exceeds the customary dietary use or ordinary compliance with the social drinking customs of the community, and that interferes with the drinker's health, interpersonal relations or economic functioning."

probate judge, by any interested party. The judge then appoints two licensed physicians to examine the patient and to report their findings as to whether or not the patient is "addicted to the excessive use of intoxicating liquors." Assuming that the physicians agree on the diagnosis and recommendation, the judge then sets a hearing date. The judge takes testimony at the hearing. The patient can demand a jury trial. He may be represented by an attorney. The judge may then adjudicate the individual to be "addicted to the excessive use of intoxicating liquors" and commit him to a mental hospital. He also determines the ability of the patient or his responsible relatives to pay for the hospital care and may include in the orders a requirement for all or partial payment. The commitment order is forwarded to the State hospital and the superintendent notifies the court when the patient can be admitted. The patient is put in the custody of any responsible citizen pending acceptance. The commitment is of indeterminate length and the time of release is determined by the hospital. The county pays the hospital costs for the first year if the patient or the family cannot pay.

Each state mental hospital is responsible for committed patients in a specific geographical area and all of the patients from any county go to the same hospital, with the following exception: if the original petitioner believes that there are extenuating circumstances which make it wise to use a State hospital other than the one normally serving that area, he may apply to the State Department of Mental Health for a waiver of district requirements. If this is approved the judge may commit to the other specified hospital.

The 1963 Legislature made two changes in the commitment laws. Under the previous law, a disagreement between the two appointed physicians generally terminated the proceedings. Proceedings could be restarted and different physicians appointed. A new law will enable the judge to appoint a third physician in the event that the first two disagreed.

Alcoholics can now be included under the 60-day diagnosis, care, and intensive treatment plan at regional diagnostic and treatment centers. Procedure is initiated as for regular commitment. The court may hear evidence and decide that a limited period of intensive treatment may make final adjudication unnecessary or the patient or his attorney may demand the diagnostic, intensive treatment program prior to the taking of testimony. Under this provision, the court orders the patient removed to the treatment center, in most cases at a State mental hospital, for a period of 60 days. This period could be extended an additional 60 days by special order of the court on the recommendation of the superintendent of the regional diagnostic and treatment center.

Alcoholics in state hospitals in Michigan get a chance to live, for awhile, protected from the pressures of normal living. They come in daily contact with mentally ill patients. They are forcibly separated from alcohol. They get a chance to become acquainted with Alcoholics Anonymous. They may have occasional routine interviews with the psychiatrist. As a result, this sort of hospital experience proves helpful to a few alcoholics. Some get into Alcoholics Anonymous when they return home and they attain sobriety through this organization. Some are so instilled with the fear of becoming "insane" that they quit drinking. These are the exceptions, however, and the average alcoholic profits little from commitment to state mental hospitals in Michigan at the present time.

Neither the hospitals nor the Department of Mental Health is satisfied with the situation as it exists. If funds were available, state hospitals could become effective treatment centers for alcoholics.

Experimental programs in alcoholism treatment have been established at Pontiac State Hospital and at Ypsilanti State Hospital. The State Board of Alcoholism has made grants to hire therapists who can devote full time to treating alcoholic patients in these hospitals. This is temporary supplemental financial support and it remains to be seen whether the programs can be continued under the regular hospital budget.

Voluntary Commitment

Voluntary hospitalization for alcoholics presents a more hopeful picture at the present time. This is partially because it is easier to help the patient who wants help and partially because there are more places where help is available. Special alcoholism treatment programs are conducted at Hurley Hospital in Flint, Sparrow Hospital in Lansing, Receiving Hospital in Detroit, and St. Joseph Hospital in Mount Clemens. There are specialized alcoholism hospitals in Detroit, Highland Park and Brighton. Each of these hospitals offers treatment for both the causes and the results of excessive drinking.

The state law that established the State Board of Alcoholism provides for a program of voluntary commitment to be conducted under rules and regulations established by the Board. Funds available to the Board are not adequate to provide care for all medically indigent alcoholics and the State plan can be used for alcoholics who show good promise of recovery. Local full-time health officers act as agents of the

Board in accepting voluntary commitments. They have a supply of commitment forms. Physicians treating alcoholic patients in need of hospital care may either work out a plan of hospitalization and follow-up care or they may ask the health officer to do so.

The commitment forms require five signatures:

1. The patient signs a statement agreeing to the long-range plan and promising to repay the State when he is able.

2. Two physicians sign the statement that they have examined the patient, found him to be alcoholic, and recommended voluntary commitment. (The health officer may sign as one of the examining physicians.)

3. The person responsible for follow-up and reporting on the patient's progress signs the form as "sponsor."

4. The health officer signs the recommendation that the commitment be accepted.

Ideally, the commitment procedure takes place when the patient is reasonably sober; however, most patients are primarily interested in help at the time they are suffering. Tentative approval can be secured by the health officer by phoning the office of the State Board of Alcoholism during the regular work week. Most hospitals will accept patients on tentative approval.

If the physician considers the patient's condition constitutes a medical emergency he may sign a notarized statement to that effect. The patient can be placed in a general hospital and five days are allowed to complete the forms. Emergency commitments are valid only in general hospitals and the statement must be completed before the patient enters the hospital. If the patient is treated in a general hospital where there is no specific treatment for alcoholism, the State limits its financial responsibility to the cost of five days. The charges for the physician's services are also covered under the voluntary commitment plan. Patients may be admitted to general hospitals and later transferred to hospitals with special alcoholism programs.

Follow-up care may be provided by local alcoholism counselling centers in Jackson, Muskegon, Grand Rapids, Lansing, Flint, Saginaw, Midland, Mount Clemens, Pontiac, and Detroit. In many cases, members of Alcoholics Anonymous, clergymen, social agencies, or physicians provide this part of the long-range treatment. This is the most difficult part of the treatment program and the selection of the sponsor is most important.

The State Board Voluntary Commitment plan provides care for about one hundred alcoholics each year at a cost of about $20,000. Many of these patients have hospitalization insurance that pays all or part of the cost.

Summary

Alcoholism is an illness with a "built-in" escape plan. Excessive drinking, originally a symptom of the illness, becomes an irresponsible escape from the negative results of the illness. In many cases, the escape possibilities of intoxication enable the patient to deny the illness and it presents inescapable problems for those around him or her. For this reason, the treatment initiative often comes from persons other than the patient and, for this reason, commitment will remain an important part of the treatment for some alcoholics.

Medical Maxims

Postmenopausal bleeding calls for cystoscopic investigation if there is any uncertainty as to its origin.

After withdrawal of steroids, the patient should be watched for at least a year because there may be little adrenal reserve to support him during illness or surgery.

The physician should avoid treating his own nervous symptoms at the expense of the patient.

In carbon monoxide poisoning, inhalation of 5 to 10 per cent carbogen eliminates the carbon monoxide faster and increases the availability of oxygen to the tissues.

After 45, the mortality rate rises 1 per cent per pound over the ideal weight.—From "711 Medical Maxims II" by W. S. Reveno, M.D.; publisher, Charles C Thomas, Springfield, Illinois.

The General Hospital—A Vital Link In Rehabilitating Alcoholics

T. S. Conover, M.D.
C. K. Stroup, M.D.
William L. Keaton, M.S.P.H.
Flint, Michigan

WHEN the Council on Mental Health of the American Medical Association recommended to the House of Delegates in 1956 that alcoholics should be admitted to hospitals and cared for as other patients, Hurley Hospital, Flint, Michigan, an 11 story, 716 bed, non-sectarian general hospital had been admitting diagnosed alcoholics as patients for 20 years. Since 1956 Hurley Hospital has pioneered in developing a special service to supplement attending physicians in the medical management of alcoholics in a hospital environment. Today the admission and treatment of alcoholics at Hurley Hospital are as routine as they are for cardiacs, diabetics, or epileptics. Under no circumstance has the diagnosis of alcoholism or the patients' degree of intoxication been a barrier to his seeking and obtaining hospitalization and medical treatment for this disease. In our community both medical and hospital personnel consider any state of acute or chronic alcoholism as a potential medical emergency that requires medical management.

Physicians Verify Need for Medical Management of Alcoholism

One hundred eight replies to a 17-question questionnaire submitted to the Genesee County Medical Society, December 1962, relative to "Alcoholism: Its Medical Management," indicated: (1) that 94 per cent of the physicians consider the alcoholic's recovery from acute and chronic alcoholism or intoxication as a medical function and responsibility; (2) that 90 per cent of the physicians considered inability to stop drinking, prolonged intoxication, asking for help, medical and psychiatric involvements, physiological pathology, and delerium tremens conditions under which alcoholics should be admitted and treated in general hospitals; (3) that physicians prefer the following procedures in medical management of alcoholics: (a) 7 to 10 days hospitalization with drug therapy and/or medication, (b) referral for participation in the Group Therapy Program, preferably on the first or second day of hospitalization, and (c) continued medical supervision upon discharge from the hospital with referral to Alcoholics Anonymous and/or other therapeutic agencies for continuing recovery programs; (4) that 95 per cent of the physicians agreed that getting the alcoholic to cooperate, recognize and fully accept his alcoholism diagnosis were the most difficult problems in treating and handling alcoholics; (5) that 87 per cent of the physicians pointed out that it requires from 26 to 76 hours or more of specific and directed individual counselling and group therapy to motivate and stimulate the alcoholic to fully recognize and accept his disease, and (6) that 72 per cent of the physicians believed Hurley Hospital's Alcoholism Program had adequately supplemented the medical management of their alcoholic patients.

Department of Medicine Initiates a Two-Year Project

In cooperation with Hurley Hospital's administrative staff, the Department of Medicine appointed a Medical Director in June 1956 to organize services to supplement attending physicians' medical management of alcoholics in a hospital environment. The earlier program consisted of two weekly group lecture and discussion periods to which interested physicians referred a few selected patients. Later, as the number of patients attending and participating in the service in-

T. S. Conover, M.D., formerly Co-founder and initial Medical Director, Department of Group Therapy, Hurley Hospital, Flint, Michigan; Director of Liberty House, Inc. (for alcoholics), died July 19, 1963 at Flint.

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Clayton K. Stroup, M.D., is Medical Director, Department of Group Therapy, Hurley Hospital, Flint, Michigan, and Chief, Department of Gastroenterology.

William L. Keaton, M.S.P.H., is Senior Alcoholism Therapist, (Program Director) Department of Group Therapy, Hurley Hospital, Flint, Michigan.

creased, the pilot program expanded to two daily (one-hour) group meetings, Mondays through Fridays.

Community agencies and organizations such as: The Mott Foundation, The Genesee County Medical Society, Flint's First Presbyterian Church, The Flint Committee on Alcoholism, Alcoholics Anonymous, and the Michigan State Board of Alcoholism indicated their interest in this innovation in hospital services by encouraging those engaged in developing the project and by providing temporary financial support. In late 1957 The Michigan State Board of Alcoholism matched funds with the Flint Committee on Alcoholism in order to employ a Program Director to develop the pilot project into a hospital service.

The Department of Group Therapy Emerges

In less than the two years allocated to the study, Hurley Hospital officials and the Michigan State Board of Alcoholism united to set up a Department of Group Therapy as a service unit of the hospital under the Department of Medicine. The Unit had three major functions: (1) to develop a practical hospital service to supplement attending physicians in handling and treating alcoholics in a hospital environment; (2) to develop the service as a guide for other hospitals; and (3) to develop an orientation and training center for therapists, interns, and residents.

Even though the Group Therapy Unit was planned for hospitalized patients, it has expanded to include advanced group therapy sessions for out-patients who have participated adequately in the in-patient or primary services.

Organization and Administration

The Department of Group Therapy, an ancillary medical service unit, is designed to supplement attending physicians in the medical management of male and female alcoholics. Administratively the department is responsible to the Hospital Director and clinically to the designated Medical Director appointed by the Department of Medicine.

The staff consists of a clerk-stenographer, two alcoholism therapists, and a senior alcoholism therapist as head of the department. In addition, clergymen and members of Alcoholics Anonymous participate regularly in the Group Therapy Program.

Administratively, the unit is set up to function as a hospital service on a par with other similar departments such as Physical Therapy or Social Service. Accounting and expenditures for the Department are modified to conform with policies and procedures as contained in the contract with the co-sponsoring agency—The Michigan State Board of Alcoholism.

General Procedures

The Department of Group Therapy is designed and organized to function as an integrated unit of the hospital and its general operational procedures fall within established hospital policies, practices, and methods of operation. However, due to the program's uniqueness, some of its major operational procedures are presented in the following paragraphs to show the patients' movements while in the hospital.

Admission to the Hospital.—Alcoholics are admitted to the hospital through the emergency department or directly through the admitting office under the supervision of their attending physicians. The group therapy clerk compiles a complete list of all admissions for each patient admitted to the hospital with an alcoholism diagnosis and for other patients without alcoholism diagnoses if they are referred to Group Therapy. During a two-year period, 1959-1961, 70 per cent of 1,334 alcoholic admissions to the hospital had an admitting diagnosis specifically designating alcoholism. In the event the patient did not have a family physician and indicated need for hospitalization, he was admitted to the hospital under the supervision of a staff doctor. There are no restrictions regulating the number of admissions, and none preventing the patient from being admitted while under the influence of alcohol.

Housing.—During the two-year study period, and up until 1961, alcoholics admitted with an alcoholism diagnosis or under the influence of alcohol were housed in the psychiatric ward exclusively. Since that time alcoholics have been housed indiscriminately on all floors (medical, surgical, or psychiatric) as the patient's condition or need has indicated. Announcement of this unrestricted housing policy for alcoholics brought waves of requests from hospital personnel, nursing supervisors, ward clerks, and orderlies for orientation and lectures on alcohol, alcoholism, and the alcoholic. Patients who become hard to manage or show signs of developing delirium tremens are transferred immediately to the Intensive Care Unit or to the psychiatric ward to be placed in a restraining room.

Medical Management.—The alcoholic patient is admitted to the hospital and remains under the supervision of his attending physician until he is discharged. All physical examinations, laboratory tests, medications and treatments, referrals for psychiatric examination and evaluation, and referrals to participate in the Group Therapy Program must be handled by the patient's attending physician. Treatment procedures vary in regard to the patient's condition, needs, and in

HURLEY HOSPITAL ALCOHOLISM PROGRAM

Group Therapy Schedule

MORNING 9:30-11:00 A.M.	AFTERNOON 2:30-4:00 P.M.	EVENING 6:30-8:00 P.M.
Monday "Introduction to Group Therapy and Ethyl Alcohol"	*Monday* Group Discussion	*Monday* "The Visual and Submerged Aspects of Alcoholism" (Iceberg)
Tuesday "Symptoms and Phases of Alcoholism" (Jellinek Chart)	*Tuesday* Group Discussion	*Tuesday* "The Chronic and Progressive Aspects of Alcoholism"
Wednesday "The Alcoholic's Need for Spiritual Adjustment"	*Wednesday* Group Discussion	*Wednesday* "12 Steps and 12 Traditions of Alcoholics Anonymous"
Thursday "The Need for Supportive Therapy in Maintaining Sobriety"	*Thursday* Group Discussion	*Thursday* "The Role of Attitudes in Recovery from Alcoholism"
Friday "Six Basic Steps in Recovery from Alcoholism"	*Friday* Group Discussion	*Friday* "Overview of Alcohol, Alcoholism and the Alcoholic"
Saturday "Mental Health in Personal and Social Adjustment"	*Saturday* Group Discussion	OUT-PATIENT SERVICES: Non-hospitalized individuals may attend Group Therapy upon referral by a physician. For maximum benefit, relatives should attend Group Therapy along with patients.
Sunday "Common Sense Philosophy for Everyday Living"		

accordance with the physicians preferences. The physician-patient-hospital relationship for the treatment of alcoholics is unique and places many services at the disposal of the physician in treating his patient.

Patients participating in the Group Therapy Program show increased emotional control; willingness to cooperate and follow instructions; and indicate greater recognition and acceptance of their alcoholism. Likewise, members of the patient's family referred to Group Therapy show increased understanding of the problem and marked ability to assist the alcoholic in his return to normalcy.

Referrals.—All patients in the Group Therapy Program are referred by their attending physicians. Referral usually appears as a written order on the patient's chart. Even though the physician may prescribe Group Therapy for his patient, there are no mandatory regulations compelling him to attend. Up to 25 per cent of the alcoholic patients are not referred or refuse to attend Group Therapy.

Patients are usually informed by their physicians if they are to attend and participate in the sessions. However, in 5 to 10 per cent of the cases, the patient has not been informed and it rests upon the therapist to explain and interpret the Group Therapy Program. Only a small per cent of the patients exhibit open resentment and hostility toward the program or the therapists.

Patients are escorted from their rooms or wards to the Group Therapy Meeting Room on the Second Floor of the hospital. On occasions, alcoholic patients will invite non-alcoholic patients to attend the Group Therapy Sessions with them.

Participation In Group Therapy.—Experience indicates that patients show far more psychological readiness for motivation and stimulation if referred to Group Therapy before they have recovered from acute intoxication than they do if it is postponed until they are completely sober. Patients usually start attending the sessions on the first or second day after admission to the hospital and continue in attendance until they are discharged. The informal atmosphere and the ease with which identification is established in the group are of such nature that patients relate to each other easily and feel comfortable in talking, asking questions, and discussing their problems.

Patients Progress Reports.—Comments, observations, and progress of each patient are recorded relative to the following: (1) admissions, previous and current attendance, and participation in Group Therapy; (2) therapists comments and observations concerning patients progress and responses; (3) patient's attitudes toward Group Therapy, acceptance of alcoholism, continued medical supervision, and supportive therapy; (4) reasons expressed for drinking; and (5) patient's degree of sincerity, motivation, cooperation, and participation.

The department also makes use of an Information and Progress Sheet to keep the attending physician informed of daily attendance and general progress. Most attending physicians rely heavily upon this daily report to determine discharge readiness. Upon each patient's discharge from the hospital, a summary of his progress and responses in Group Therapy is forwarded to the attending physicians and a copy is retained for his medical record.

Group Therapy Services

Basic concepts undergirding the Group Therapy Program are: (a) alcoholics need medical care, (b) the family physician is the key figure in treating and rehabilitating alcoholics, (c) both private and general hospitals can admit and provide tools, techniques, and adequate services to supplement physicians in handling and treating alcoholics, and (d) alcoholics will respond favorably to a combination of medical and ancillary

services if given reasonable concepts of what the disease is; acceptable explanations of how the disease developed; recognizable symptoms and stages of the progressive malady; and some functional and practical steps in recovery.

The supplemental educational and psychotherapeutic services consist of 18 1½-hour lecture-demonstration-discussion periods per week centered around pertinent aspects of alcohol, alcoholism, the alcoholic and related emotional problems. They are designed: (1) to help the attending physician handle and treat his patient; (2) to help the patient help himself—especially in "wanting help"; (3) to help members of the patient's family help the patient, and (4) to help the patient recognize the need for continued medical supervision and a recovery program.

All lectures are designed and presented to formulate accurate concepts and to enhance understanding and acceptance on both the intellectual and emotional levels. During all presentations, even the discussions, extensive use is made of the blackboard for diagrams, illustrations, and drawings. In addition, films are used as adjuncts to supplement lecture-demonstrations and as springboards for discussions.

The accompanying Group Therapy Schedule indicates the general areas of the problem covered and the specific subject dealt with during each meeting. Even though the series extends over a seven-day period, each session is semi-complete, thus making it easy for patients to join the group at any time. Patients tend to rate the group discussions far above the more formal lecture-demonstration sessions. However, when this discussion period is used as the basic core of the program, its role and degree of importance diminishes very significantly and patients themselves ask for factual information.

Professional and lay people interested in the problems of alcoholism; the techniques of motivating alcoholics; and developing hospital services to supplement attending physicians in the medical management of alcoholism are invited to observe the Group Therapy Program in action and to participate in its activities.

Summary and Results

The Alcoholism Unit at Hurley Hospital is an innovation in hospital services and a vital link in a definitive program for medical management and rehabilitation of alcoholics. Attesting to the significance, acceptance, and practicality of the service unit are the following:

1. Three Michigan Hospitals, Edward W. Sparrow Hospital of Lansing, St. Joseph Hospital of Mount Clemens, and Pontiac State Hospital of Pontiac, Michigan, are developing similar alcoholism units.

2. Two alcoholism units, Sagnaw County Information Center on Alcoholism and Macomb County Alcoholism Information Center, are using the basic core of Hurley's Alcoholism Program in conducting their information and education programs.

3. A total of 175 local physicians have utilized the service through 2,987 referrals to the Group Therapy Program.

4. A total of 58,091 cumulative hours (patients 41,214 hours, relatives, visitors, professional 16,877 hours) of orientation, group therapy, and counseling were provided by the Group Therapy Staff since June 1, 1958.

5. Significant inroads have been made in reducing chronic alcoholic repeaters, in reaching alcoholics at an earlier age, and in motivating physicians to hospitalize their alcoholics as alcoholics.

6. Attitudes of administrative, nursing, clerical, and service personnel indicate significant modifications for the better toward accepting alcoholics.

7. The basic In-patient Group Therapy Unit has been expanded to include Primary and Advanced Outpatient Services.

8. An alcoholism orientation and training program has been initiated for Medical Residents.

Ipecac for Emergency Use

Syrup of ipecac empties the stomach in approximately 16 minutes and probably is more effective than a stomach washing following accidental ingestion of poison, report Drs. Frederick J. Margolis and James A. Dugger of Kalamazoo. The trick, however, is to have the ipecac (syrup) in the household when the child takes the poison. The physicians solved this problem by having a local drug store supply them with half-ounce bottles of ipecac to be given to each of their patients. Parents are advised that if the child should take poison to call the pediatricians for the proper dose to use. "Since we started this practice two years ago, we have gone out of the stomach-pumping business, but our poisoning cases continue at the same rate, about one case a day." Acetylsalicylic acid (aspirin) tablets are the principal offender, they said.—*American Journal of Diseases of Children*, February, 1963.

In-Patient Versus Out-Patient Alcoholism Rehabilitation

W. B. Prothro, M.D., M.P.H.
Grand Rapids, Michigan

SINCE September 1955, the Grand Rapids-Kent County Health Department has administered an alcoholism rehabilitation program. For the first four and one half years, the program centered around an in-patient facility. The last three years it has operated as an out-patient program. During this period, more than 1,200 patients have been assisted with an overall success rate of approximately 60 per cent. This has provided us with an excellent opportunity for comparing the effectiveness and cost of the two approaches toward rehabilitation.

In both programs, the philosophy that has guided our organization and operation is that an alcoholic is an ill person physically, mentally, spiritually and socially. As such, his need is multiphasic. The arts and sciences of all professional disciplines that compose the health department staff, in cooperation with those of other individuals and groups in the community, have been utilized in a team effort to effect rehabilitation.

Primary Prevention—Health Education

From the start, we have addressed ourselves to both primary and secondary prevention of alcoholism. Primary prevention is attempted through an organized public health educational program. This has included news releases, radio and television programs, distribution of educational materials, consultation to public and private school personnel, and cooperation with the Kent County Council on Alcoholism in maintenance of a Speaker's Bureau on alcoholism, sponsorship of workshops, and other educational programs.

Efforts are made to motivate alcoholics to seek professional assistance in solving their problem. Referrals are made to the agency that can offer the greatest help. Much of the educational program is designed to develop better citizen understanding of the problems of the alcoholic, the community's responsibilities in helping prevent people from becoming addicted to alcohol, and in the rehabilitation of those that are.

Doctor Prothro is Health Director of the Grand Rapids-Kent County Health Department, Grand Rapids, Michigan.

Secondary Prevention—Through Rehabilitation

Prior to 1945, the only public institutions that admitted alcoholics were the jail and, in terminal cases, the mental hospital. Once the alcoholic started drinking, the only direction was down. There was no turning back. He was rejected by society. He soon lost his job, home, family, and friends. He became a homeless man—a skidrow bum! His only hope for the future was jail, insanity, or premature death.

Our first approach at working with the chronic alcoholic was to establish and operate a 15-bed in-patient rehabilitation center. Our goal through secondary prevention was to assist in the rehabilitation of the chronic alcoholic who, while sober, sincerely desired to overcome his addiction. Our objective was to provide medical, social, spiritual, and educational assistance in an acceptable manner and individually blended to meet the need of the various alcoholics.

Patients have always been admitted to the Alcoholism Rehabilitation Center on a voluntary basis. Most patients sought admission either while in the remorseful stage following a "drinking spree" or when facing a crisis such as the loss of their job, a threat of divorce, the prospect of commitment to a psychiatric hospital, the prospect of losing their driver's license, arrest for driving under the influence of liquor, et cetera.

Detoxification was seldom the primary purpose for admitting a patient to the in-patient facility, although this was done occasionally as an initial step. Rather, admission provided a time and place for the alcoholic to be removed from his previous environment and to receive medical, psychological, and social evaluation and treatment. It also provided the patient an opportunity to obtain scientific information on the effects of alcohol on the body, and the community resources available to assist alcoholics in overcoming their addiction. The medical therapy, social counseling, and education aspects of the rehabilitation program were supplemented with a high protein diet, recreation, adequate sleep and occupational therapy.

In such an ideal setting, and with good professional help, we hoped to "convert" the alcoholic to a new way of life. While he was being treated for the effects of past drinking, an all-out attempt was made to give him knowledge of himself and alcohol, and motivation strong enough to enable him to give up totally the use of alcohol thereafter.

Out-Patient Rehabilitation

Beginning July 1, 1960, we closed our in-patient facility due to budgetary restrictions and concentrated our efforts on the information center and an out-patient rehabilitation program.

Thirty-four per cent of those seeking assistance during the first years of our out-patient program were acutely ill and required from three to five days hospitalization for detoxification. To meet this need, the health department took the initiative of getting general hospitals to admit the acutely ill alcoholic the same as any other ill person. Physicians were encouraged to be more understanding of the alcoholic and to assume responsibility for detoxification and medical treatment as well as referral to the Rehabilitation Center for long range follow-up and supportive care. A program of financial assistance for medically indigent alcoholics to cover medical and hospital treatment costs was developed in cooperation with the State Board of Alcoholism. Under this program, the Alcoholism Center staff screens applicants for eligibility, arranges for needed medical and hospital care, and provides social casework with admitted patients before, during and following hospitalization. Upon release from the hospital, the patients are continued upon rehabilitation therapy in the Alcoholism Out-Patient Center. Patients are asked to repay treatment costs when and if they can.

The basic approach to our rehabilitation effort has remained the same throughout the in-patient and out-patient periods of our program. The procedure used in the out-patient clinic is as follows:

Initial Interview—Individuals who request information or assistance from the Rehabilitation Center are first interviewed by a social worker. The rehabilitation program is reviewed and discussed with the patient along with other community resources. The desirability of admission to the out-patient program is determined at this time.

Medical Care—Patients are next seen by the clinic physician who takes a medical history and makes a physical examination along with appropriate laboratory tests. He passes judgment upon whether there is an underlying psychosis or other emotional, mental or physical problem that must first be treated. He diagnoses and treats the complications of alcoholism such as gastritis, peripheral neuropathy and malnutrition, and initiates a program of supportive counseling and drug therapy individualized to the patient's needs. Drugs are furnished at cost, or free if the patient cannot pay for them.

Counseling and Group Therapy—Patients are then started on a program of individual and group counseling. Early interviews are scheduled with a social worker or the physician on an individual basis. As soon as thought feasible (generally within the first two or three weeks), they are placed in group counseling or small group therapy sessions. All patients are urged to attend a basic series of eleven lecture-group therapy sessions over an eleven week period. These are designed to give better understanding of alcoholism as an illness and general information about alcoholism. They explain what help the alcoholic can expect from medicine, psychiatry, social agencies, the church, Alcoholics Anonymous, Family Service and other community agencies and resources. The individual is given a chance to ask questions and discuss his feelings with others. The subjects covered in the lecture-group therapy series are: Medical treatment, progressions of alcoholism, basic needs and drives, physiology and pathology, problem solving, nutrition and alcohol, emotional patterns, maintaining sobriety, attitudes toward alcoholism, our religious needs, and discussion of the film "Alcoholism."

Cooperating in the presentation of these are the physician, social worker, nutritionist, and health educator.

In addition to the above, each patient and his or her family are urged to participate in a continuous education and group therapy program that is conducted each Thursday evening. These programs vary each week, from outside speakers and panel members to films and socio-dramas. Separate group therapy sessions are conducted for wives and other relatives. The group meets once a month in the main clubroom of Alcoholics Anonymous where the patient becomes acquainted with A.A. members and the A.A. program. Patients are encouraged to join A.A. Those with religious interests are referred to a Priest, Minister or Rabbi of their choice, or, if they have none, to a member of a ministerial committee which has been selected by the Ministerial Association.

Follow-Up and Supportive Care—After initial treatment and completion of the basic lecture and group

TABLE I. LENGTH OF HOSPITALIZATION OF 416 IN-PATIENTS

Days	*Per Cent*
1- 5 days	8
6-10 days	11
11-15 days	59
16-20 days	16
21-25 days	5
26-30 days	1
	100

therapy sessions, patients are permitted to schedule appointments with the physician or a social worker at any mutually agreeable time for such medication and supportive care as is needed.

When a patient is originally admitted, a public health nurse is assigned to work with the family, if there is one. The nurse shares in the responsibility of encouraging the wife (or husband) to develop insight and understanding of the problem by stimulating her participation in the health department Thursday evening educational and group therapy sessions, the A.A. meetings, their church services, etc.

If there are other health problems in the family, assistance is given in recognizing them and in developing a plan for their correction. She helps evaluate the home environment and its relationship to the alcoholism problem and shares this information with the entire rehabilitation team.

The nurse provides a minimum of eight follow-up home visits over a period of two years to provide support to the patient, health supervision to the family, and necessary information for program evaluation by the staff.

Program Evaluation

General Information—By preplanning, an evaluation system has been established through our record system. Social, economic and medical histories are taken at the time of admission and kept up-to-date at time of patient's visit to the Center and quarterly home follow-up visits by the nurse.

In-Patient Program During Three Years (September 1955-August 1958)—During the first three years of existence our Alcoholism Rehabilitation In-Patient Center had 781 admissions (an annual average of 260). However, only 614 individuals were involved since 142 (23 per cent) returned for a second, and, sometimes a third treatment.

In August and September of 1958, a survey was made to determine the status of our former in-patients. At the time of this survey all contact had been lost with 129 patients (21 per cent of the total 614 persons treated). Out of the remaining 485 patients (79 per cent), 45 persons were confined (23 to various medical institutions and 22 to prisons or jails), and 24 persons were dead. Reports on the remaining 416 patients (68 per cent of the total) were studied in detail.

The complete results of the survey have been published,† so I shall mention only a few of them here for the purpose of comparison.

TABLE II. DRINKING STATUS OF 416 IN-PATIENTS AT TIME OF SURVEY**

Drinking Status	*Per Cent*
Does not drink or drinks much less	62
Drinks as much, nearly as much, or more	38
	100

**Data on drinking improvement is based on a general evaluation made by public health nurses or members of the Alcoholism Rehabilitation staff.

Out-Patient Program for One Year (September 1960 to September 1961).—In September 1962, a study was made of the results of our first year's experience in the out-patient alcoholism rehabilitation program. The results of this study have been reported in detail in a paper presented to the American Public Health Association at its 1962 annual session. I shall mention only a few of them here for the purpose of comparison.

TABLE III. LENGTH OF STAY ON OUT-PATIENT SERVICES OF 98 NEW OUT-PATIENTS*

Days	*Per Cent*
Under 31 days	10
31 days- 90 days	4
91 days-180 days	5
181 days- 2 years	81
	100

*Only patients admitted for the first time between 9/1/60 through 8/31/61 are included in this study. Many other patients were provided service as numerous former in-patients were still being provided supportive care.

One of the difficulties in evaluating an out-patient program, or comparing it with an in-patient program, is the fact that all do not obtain the same amount of service. Some drop out of the program sooner than others. Some can't or won't participate in the total program. For this reason, we also studied the kinds and amounts of service received by the patient included in Table III. This analysis revealed that only 87 per cent of the patients admitted to the out-patient clinic participated to any degree in the major parts of the rehabilitation program; i.e., consultation with the social worker, with the physician, and attended part or all of the educational and group therapy sessions.

Forty per cent of the patients received five or less consultations with the social workers. These showed

†"Alcoholics Can Be Rehabilitated"—*American Journal of Public Health*, 51:450 (March) 1961.

an improvement in sobriety of only 33 per cent as contrasted to an 80 per cent improvement for those who had 16 to 20 such consultations.

Forty-four per cent of those seen by the physician five or less times were found sober or markedly improved as contrasted to 76 per cent of those seen 6 to 10 times.

TABLE IV. DRINKING STATUS OF 98 NEW OUT-PATIENTS AT TIME OF SURVEY*

Drinking Status	*Per Cent*
Does not drink or drinks much less	53
Drinks as much, nearly as much, more, or unknown	47
	100

*Data on drinking improvement is based on a general evaluation made by public health nurses or members of the Rehabilitation staff.

It was found that 41 per cent of the out-patients attended only three or less of the educational and group therapy sessions. Only one out of three of these reached sobriety or showed marked improvement. Of those patients attending more than three of these sessions, 75 per cent improved or reached sobriety.

In looking at the overall results of the out-patient program, we realize that the greater the participation in the service program by the alcoholic the greater were the probabilities for rehabilitation. More effective ways are being sought, and must be found, for motivating the alcoholic to full participation in the rehabilitation program if we are to improve our results.

Statistical Comparison of In-Patient and Out-Patient Program.—A detailed study had been made comparing the last year of our in-patient program June 1, 1959 to May 31, 1960 with the first year of our out-patient program September 1, 1960 to August 31, 1961. A comparison of a few selected characteristics is shown in Table V.

From this study, we note that the number of admissions decreased when we changed to an out-patient service, but the per cent classified as chronic alcoholics remained approximately the same. Otherwise we note significant changes in the characteristics of the new patients admitted to the Out-Patient Rehabilitation Center.

Some of the changes we consider good are: The patients in general are younger, more still live with their families, fewer are divorced, more are employed, and, in general, few had progressed in their drinking habits so as to be classified as "skid row." By providing help at this earlier stage we have a better chance of aborting the condition and preventing disruption of

TABLE V. SELECTED CHARACTERISTICS OF COMPARISON OF IN-PATIENT AND OUT-PATIENT PROGRAM

Selected characteristics at time of admission	*In-Patient Admissions*	*Out-Patient Admissions*
Number of patients:		
New Admissions	147	98
Readmitted from previous years	79	54
Total Admissions	226	152
Per cent new admissions	65%	64.5%
Per cent of new admissions in chronic stage of alcoholism	46.9%	44 %
Per cent of new admissions employed (full or part-time)	49 %	61.2%
Median age	40-49 yrs.	30-39 yrs.
Percent of new admissions living with spouse or other relatives	55.1%	72.4%
Percent of new admissions divorced	23.1%	8.2%
Annual program cost per patient treated	$300.00	$156.00
Per cent showing complete sobriety or significant improvement at last known contact	62%	53%

one's home, loss of job and self respect, trouble with the law, et cetera.

Another thing that makes the out-patient program attractive is that the annual cost per patient treated is only half as much as our former in-patient program.

The only adverse point noted is a 14 per cent decrease in effectiveness of the program. Naturally, with more staff and facilities one can expect better results, but with finances limited we have been able to get more per dollar invested in an out-patient program.

In conclusion, I would point out that there are advantages and disadvantages to both types of programs. The in-patient service has the advantage of a better environment, assurance of more total participation in the various aspects of the program, and it has shown a higher per cent (62 per cent) rehabilitation. It has the disadvantage of costing more because it attracts more advanced or rather hopeless alcoholics. The fluctuation in occupancy of the in-patient facility makes it uneconomical unless it is operated in conjunction with a hospital or health department so that the staff can be profitably used in other services when the patient load is small.

The out-patient service is less costly to operate and tends to attract the alcoholic earlier in his or her addiction. This is the most effective and logical time to attack the problem.

Both approaches, while far from perfect, are much more effective than previously thought. They strongly suggest that alcoholism is an illness and a public health problem. As such, it should not be ignored nor treated merely as a public nuisance and a police problem. Even if we ignored the important human and spiritual values involved, economic self interest should demand widespread study and trial by others. If others find that they can reproduce or improve upon our results, then alcoholism rehabilitation should be accepted as a part of all good community health programs.

MICHIGAN DEPARTMENT OF HEALTH
ALBERT E. HEUSTIS M.D., State Health Commissioner

Fluorescent Antibody Technique

Eaton Agent Pneumonia

Using a recently developed fluorescent antibody test, the Virology Unit of the Division of Laboratories reports it has uncovered its first case of Eaton Agent pneumonia, one of the serious respiratory infections. This type of "virus" pneumonia is caused by an organism that is, in fact, neither virus nor bacterium, but has some of the characteristics of each. The Eaton Agent belongs to a group of micro-organisms known as the PPLO (Pleuropneumonia-like organisms), which are much smaller than most bacteria and are difficult to grow in the laboratory. The PPLO come in all sorts of shapes and may even change their form from day to day. They cause various animal as well as human disease. Eaton Agent was found to be a PPLO in 1961-62, a step which led to fluorescent antibody technique for accurately diagnosing Eaton Agent pneumonia.

The fluorescent antibody test utilizes a special dye which fluoresces when viewed under an ultra-violet light microscope. The effectiveness of the test derives from the fact that the dye when complexed with specific antiserum will attach itself to the antigen against which the serum was prepared. At present the FA test is the most reliable and specific one available for diagnosis of primary atypical pneumonia caused by Eaton Agent. Since this disease ranks high in occurrence among serious respiratory infections, it is anticipated that the new test will be of considerable value in differentiating viral pneumonias in Michigan.

Rabies Diagnosis

The Virology Unit of the Laboratories has used the Fluorescent Antibody Technique in rabies diagnosis unofficially for the past one and one-half years. This experience has led to the conclusion that its reliability is on a par with the mouse inoculation technique.

In order to expedite the results of rabies diagnostic procedures, specimens from the following animals will undergo direct examinations and FA techniques only:

(a) Rodents kept as domestic pets, such as white mice, hamsters, rabbits, guinea pigs, white rats.
(b) Wild rodents, specifically rats, squirrels, and field mice.

Direct examination and animal inoculation tests will be used in all other species submitted for rabies examination. Conventional tests will be supplemented by FA technique in instances where direct or animal inoculation results are equivocal.

FA tests will be conducted on Tuesday and Friday of each week and results will be reported the day of the test.

Dental Research

The state health department has been awarded a $190,000.00 grant from the National Institute of Dental Research to support a four-year study of topical fluoride applications.

The project, to evaluate the effect on tooth decay by various topical solutions of fluoride, techniques of application, and the effectiveness of three prophylactic pastes, started September 1 and will run through June, 1967.

The Flint Board of Education and the Superintendent of Schools, Dr. Lawrence E. Jarvie, have granted permission for the project to be conducted in the schools of Flint.

At least twenty-five hundred second and third graders will participate in the study. A team of four clinical dental hygienists will apply the various fluoride solutions directly to the children's teeth during the first three years of the study, with the fourth year being devoted to dental examinations. Chief dental hygienist for the project is Miss Laura Beckwith of Jackson, Michigan.

Principal investigator on the project is health department dentist, Dr. Louis Szwejda, and co-investigators are Dr. Chester V. Tossy, Director of the department's Dental Division and Miss Dorothy Below,

(Continued on Page 1011)

Why Not Treat Alcoholics?

By Richard C. Bates, M.D., Lansing
Chairman, MSMS Committee on Alcoholism and Drug Addiction

Alcoholism is a disease. The AMA House of Delegates said so in 1956; the United States Public Health Service and the World Health Organization agree.

Yet there are few physicians in all of Michigan who welcome these problems to their practice.

Physicians who practice general medicine are obligated to diagnose and treat all diseases, mental and physical, or secure adequate facilities for their patients by referral. Since one adult in 20 is an alcoholic and there are not nearly enough psychiatrists in this field, each general physician must treat his own cases or fail in his obligation.

Doctors who reject alcoholics have as many and as flimsy excuses as the alcoholic does for drinking. Let's look at some of the common ones:

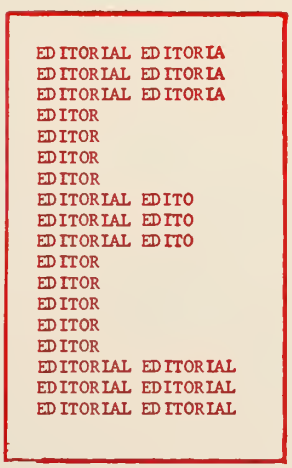
Excuse:
They take a lot of time.
Answer:
So does open heart surgery; so do diabetics. Think of them as having a potentially fatal disease, charge them for your time and you won't begrudge it. Some of the therapy can be delegated to others, but not *all* of it.

Excuse:
They tell a lot of lies.
Answer:
So do fat ladies on diets.

Excuse:
Alcoholics don't pay their bills.
Answer:
Yes they do. If anything, a little better than average.

Excuse:
They're hopeless.
Answer:
Terminal cancer and leukemia are, but alcoholism can be arrested in at least 50 per cent of the cases who come for help.

Excuse:
Alcoholism is a mental disease and I'm not a psychiatrist.
Answer:
If you can get fat people to take off weight and smokers



to stop, you have most of the skills you need.

Excuse:

I don't know how.

Answer:

You can learn. Members of A.A., some of whom have less than a high school education, can give you some pointers.

Excuse:

They'll take over my practice.

Answer:

Not if everyone does his share. Anyway, you could do worse. Doctors have achieved great success helping alcoholics.

Excuse:

There are too many people who want to be well to waste time on people who want to be sick.

Answer:

Then you'd better stop seeing fat people and smokers; better add people who work too hard and don't get enough exercise to the list, too.

Perhaps, deep down, these all boil down to three: (1) "No one taught me in medical school how to handle this disease"; (2) "I don't think it would be as rewarding and satisfying as the work I'm doing now"; (3) "I'm uncomfortable when faced by diseases with mental and moral connotations."

In this JOURNAL, you will find many helpful suggestions for therapy. Why not try a few cases and see how it goes? It's a little like learning to swim: it looks formidable from the shore, but if you relax and do what comes naturally, it ends up being rather fun.

A Fringe Benefit to Patients

By Allan Barth, Lansing
Executive Director, Michigan Hospital Association

Whether they are called volunteers or volunteens, auxilians or gray ladies, the almost 70,000 women, men and teenagers who unselfishly devote their time and energy to performing a multitude of services in and for the hospitals of Michigan constitute a fringe benefit for patients that few ever realize. Without their contributions of time, talent and dollars, hospital bills would be higher; patient comfort and peace of mind would be lessened.

In 1961, adult volunteers contributed a total of 1,023,011 hours to 128 Michigan hospitals. These hours amounted to 25,575 work weeks of 40 hours each—or 511 years of work time based on the 50-week work year. At the same time, teenage volunteers contributed a total of 158,784 hours to 85 Michigan hospitals. Their contribution amounted to 3,970 work weeks or 79 years of work.

During the 1962 calendar year, organized hospital auxiliaries contributed a total of 7,802,733 hours of service to 64 hospitals in Michigan. In addition, the auxiliaries gave over a half million dollars raised from the operation of gift shops and other money making efforts. The scope of this contributed service can be illustrated by the fact that these hours amount to 195,068 work weeks or 3,901 years of work time. In other words, each of the 64 hospitals received an average of 121,917 contributed hours during the year. This average is equivalent to 3,408 work weeks, or a total of more than sixty contributed work years.

What do these wonderful people do? Almost everything. From staffing information desks, gift shops, to performing library service, escort service, messenger service, mail delivery service, providing nursing service assistance in making empty beds and feeding patients, helping in pediatrics by feeding and entertaining children, working in central supply with the preparation of materials for sterilization and distribution throughout the hospital, performing dietary service such as assisting patients in using selective menus, collecting menus, taking care of the flower service, doing clerical work, and serving as coffee shop waitresses—in short, you will find a volunteer at work wherever there is a job to be done and the supply of professionally trained personnel is short.

Millions of dollars of equipment have been purchased in Michigan with funds raised and donated to hospitals by auxiliaries and volunteers. Tag days, bazaars, rummage sales, anni-

versary balls, style shows, horse shows, picnics —you name it—they do it.

To fully appreciate what the volunteers and what the auxiliaries do for hospitals, just eliminate the services they perform. But if you do, beware. Without these dedicated people who sacrifice so much of their time to the basic humanitarian ideals of community service, without this element of charity our voluntary hospital system would suffer and patient care would decline.

Who are these volunteers? They are the fringe benefit a patient never pays for.

Once Upon a Time

Once upon a time there were knights in armor, ladies in waiting, peasants, serfs, strolling minstrels, castles, and a lord of the manor —all part of a feudal society. Under feudalism, the lord of the manor was responsible for a secure "social system." All of the produce of the peasant and serf became his and, in return, food, a hovel to live in and other basic necessities, including such medical care as was available, were provided. With the passage of time and with the impact of individual initiative and private enterprise, this system was abandoned as unfair, inefficient, and stifling to free men.

How strange, indeed, the modern labels of "liberal" and "conservative," when one realizes that the current liberal trend, is indeed back toward feudalism with the Federal government in the role of the lord of the manor. It would appear, then, that our modern conservatives are the genuine liberals and our liberals are engaged in a move toward a social system that is decadent, retrogressive, inefficient, and stifling to freedom, healthy competition, and independent enterprise.

Thank You

The excellent series of scientific articles about alcoholism published in this number of THE JOURNAL was developed by the MSMS Committee on Alcoholism and Drug Addiction. Coordinator for this series was Richard C. Bates, M.D., Lansing, the committee chairman.

A special grant from the Michigan State Board of Alcoholism helped to make it possible to print the full series of articles. MSMS wishes to thank the Committee, Chairman Bates and the State Board of Alcoholism.

MICHIGAN DEPARTMENT OF HEALTH

Dental Research

(Continued from Page 1008)

Michigan Department of Health dental hygienist. Consultants to the project will be Dr. Fred Wertheimer, former director of the Dental Division, Michigan Department of Health, and Dr. David Striffler, Associate Professor of Dental Public Health at the University of Michigan School of Dentistry and School of Public Health.

In addition to the four hygienists, a clinical clerk and a statistical clerk will be hired for the project. The data will be tabulated and analyzed under the direction of the statistical consultant, Dr. Richard Remington, Associate Professor of Statistics at the School of Public Health in Ann Arbor.

About 100,000 Michigan children living in areas served by fluoride-deficient water receive topical fluoride applications each year through the summer topical fluoride program and through school and community-supported year-round programs.

The Michigan Department of Health is interested in improving methods of preventing dental disease, and it is hoped that knowledge gained from the study will enable an even greater reduction in tooth decay than the average of 40 per cent which past experience with topical fluoride has shown.

MSMS Centennial Series

William Beaumont, M.D., and His Studies of the Physiology of Digestion At the Michigan Gibraltar of the Great Lakes

By Alfred H. Whittaker, M.D.
Detroit, Michigan

The story of Dr. William Beaumont and his spectacular study of Alexis Bidagan dit St. Martin's digestive system has become familiar to the people of America. It is especially popular in St. Louis where school children make an annual pilgrimage to his final resting place at Bellefontaine Cemetery on the anniversary of his birth, and it is also of exceptional interest to the people of Michigan where St. Martin was accidentally injured by a shotgun blast and subsequently recovered with an open stomach wound ideal for observation.

Beaumont's observations by direct inspection of the interior of St. Martin's stomach corroborated previous theories of the nature of digestion and disproved many beliefs of earlier investigators. Reaumur[1] and Spallanzani[2] were the most important of the European physiologists to study the physiology of digestion. In 1802 in the United States, Spencer[3] had advanced a theory which Beaumont later proved as surprisingly accurate.

Doctor Beaumont's research was carried out in a frontier fort without benefit of technical equipment. Beaumont was an army post surgeon who recognized an unusual opportunity (there had been earlier gastric fistulae but the opportunity for study had been overlooked) for careful observation and exact recording. By highly intelligent interpretation, he devised a series of experiments which attracted the admiration of physiologists and clinicians throughout the world.



The Author
ALFRED H. WHITTAKER, M.D.

THE FIRST PERSON who contributed to the Beaumont saga was William Astor who developed the fur trading station (American Fur Company) on Mackinac Island, which became the first American million dollar corporation.

The site (later commemorated as the Beaumont Memorial) was part of a land grant by Lt. Governor Patt Sinclair to a British Officer who sold it to a French trader from Green Bay. In 1796, the plot was acquired by John Ogilvie of Montreal[4] who built a combined house and supply firm to the fur trade. In 1818, the building became the retail store of the American Fur Company, the stage thus being set for the accidental shooting of the company engagee St. Martin.

* * *

THE SECOND PRINCIPAL of our saga, Doctor Beaumont, was born in 1785 at Lebanon, Connecticut. In 1806, he traveled north to the little village of Champlain, New York, where he taught in the public school for three years, accumulating enough money to cross Lake Champlain to St. Albans, Vermont, where he became an apprentice to Doctor Benjamin Chandler.

At that time, a two-year apprenticeship was required to obtain a license to practice medicine. During this time, Doctor Chandler exerted an excellent influence on the mind of his assistant, emphasizing the importance of a good memory, of developing the power of observation and the habit of logical thought.

On June 2, 1812, Doctor Beaumont was granted a license to practice and he remained with his preceptor until September when, war having been declared with Great Britain, he went to Plattsburgh, New York, and joined the army as surgeon's mate assigned to the Sixth Infantry Regiment.

Surgeon's Mate Beaumont took part in numerous engagements of which he made careful notes[5] and this proved good preparation for care to St. Martin's severe injury later in 1822.

After the war, Beaumont returned to Plattsburgh

where he entered private practice. He made many friends and a deserved reputation.

By 1820, active service in the Medical Corps had become more attractive and he rejoined the army to be commissioned Post Surgeon by President James Monroe on March 18, and was immediately ordered to Fort Mackinac. He reported to General Alexander Macomb, under whom he had served valiantly in the Battle of Plattsburgh.

* * *

MACKINAC ISLAND HAD become the center of a series of trading posts established in a large territory including the shores of Lakes Michigan, Huron, Superior and the Mississippi country.

Each fall, brigades consisting of several bateaux manned by a clerk and five to eight voyageurs, set out for distant stations and returned in the spring with furs trapped throughout the winter. The American Fur Company employed about 3,000 of these French Canadian voyageurs.

Thus, by 1822, two of the dramatis personae of the Beaumont drama—Astor and Beaumont himself—were on stage.

* * *

THE THIRD PRINCIPAL of the saga, Alexis St. Martin, was born on April 18, 1794, at Berthier, Lower Canada (now the Province of Quebec).[6] His father was Joseph Bideguin dit St. Martin. Later documents show Alexis' full name to have been Alexis Bidagan dit St. Martin, "Bidagan" being a variant of "Bideguin." The family was French in origin as Alexis' paternal grandfather had come to Canada from Masparraute, a village in the extreme southwest of France within the old province of Navarre.

We know nothing of St. Martin's childhood, except that he probably grew up near Berthier. On the morning of June 6, 1822, he entered the retail store of the American Fur Company on Mackinac Island and walked into the accidental discharge of a shotgun.

The dramatic entrance of Alexis St. Martin into the Beaumont story was observed by Gurdon S. Hubbard[7] who lived in a cottage near the west bluff of the Island. (The cottage still remains in the Hubbard family and now belongs to the widow of Dr. Allan McDonald, former President of the Wayne County Medical Society, who spent many summers and entire years on the Island administering to its residents.)

Hubbard's report is accurate, but the dramatic recital of the event by Sir William Osler, who always showed great interest in Beaumont and St. Martin, is much more interesting. The following quotation is from an essay in *An Alabama Student*:

> . . . The Fort was occupied by United States troops who kept the Indians in check and did general police duty on the frontier, and the place had become a rendezvous for Indians and voyageurs in the employ of the American Fur Company. On this bright spring morning the village presented an animated scene. The annual return tide to the trading post was in full course, and the beach was thronged with canies and bateaux laden with the pelts of the winter's hunt. Voyageurs and Indians, men, women and children, with here and there a few soldiers, made up a motley crowd. Suddenly from the company's store there is a loud report of a gun, and amid the confusion and excitement the rumor spreads of an accident, and there is a hurrying of messengers to the barracks for a doctor. In a few minutes an alert-looking young man in the uniform of a U. S. Army surgeon made his way through the crowd and was at the side of a young French Canadian who had been wounded by the discharge of a gun, and with the composure bread of an exceptional experience of such injuries, prepared to make the examination. Though youthful in appearance, Surgeon Beaumont had seen much service, and at the capture of York and at the investment of Plattsburgh he had shown a coolness and bravery under fire which had won high praise from his superior officers. The man and the opportunity had met. . . .

The story has caught the imagination of many. Several years ago, Supreme Court Justice Frankfurter talked to the students of Harvard Medical College of the above in an address which he titled "A Lawyer's Dicta on Doctors." This was the George W. Gay Lecture delivered on Friday, March 21, 1958.

History shows that St. Martin recovered but retained a permanent fistula of the stomach enabling Beaumont to make and report important observations which established the principles of digestion.

* * *

A REPORT OF St. Martin's injury was first published early in 1825 in the *Medical Recorder*. Beaumont had sent a complete report to Surgeon-General Joseph Lovell for his approval and correction with the suggestion it be published in some reputable medical journal. Through an oversight, it was published as "A Case of Wounded Stomach" by Joseph Lovall,



A feature of the Beaumont Memorial is Dean Cornwell's famed painting of "Beaumont and St. Martin," a gift of Wyeth Incorporated to the Michigan State Medical Society.



The Beaumont Memorial Museum—on the exact site of the American Fur Company retail store in which Alexis St. Martin was wounded—was dedicated on July 17, 1954. The plaque on the building declares that "This building is dedicated to the memory of William Beaumont, M.D. It was restored by voluntary contributions of Michigan Doctors of Medicine and presented to the people of Michigan." A portion of the dedication audience is shown above.

Surgeon General, U.S.A. The mistake was corrected, however, and credit given to Beaumont.

The same year, Beaumont began a series of experiments which were published in detail in 1833[8] with a second printing in 1834. A second edition was printed in 1847 at Burlington, Vermont.

In June, 1825, Beaumont was transferred to Fort Niagara and took Alexis with him. Then followed years of assignments to various army posts, the experiments continuing whenever Beaumont could get Alexis to stay with him.

In 1834, Beaumont was assigned to Jefferson Barracks in St. Louis where he traveled by carriage and stage to report to General Henry Atkinson. Congress had just passed a law making the pay of a surgeon equal to that of a major. The U. S. Army still had no lineal classification of medical officers. With less financial worry, Beaumont hoped to bring Alexis to St. Louis and take him to Europe. When neither of these things came to pass, as St. Martin had disappeared, he asked the Surgeon-General to assign him to another post.

Without waiting for a reply, he set off for Washington where he learned he could return to St. Louis to take charge of purchasing medical supplies in addition to the usual duties of a surgeon. He collected his family in Plattsburgh and started west again. At Albany, he saw his first railroad.

The family proceeded to Prairie du Chien where a fellow officer remarked the post was worthy of its name, and then by steamboat to St. Louis, arriving on the levee July 23, 1835.

In the spring of 1838, the Beaumonts received an inquiry from Lt. Robert E. Lee's assistant asking whether they could accommodate Lee and his family for a month. Lee had worked out a plan for a system of piers and dykes which would turn the current of the Mississippi and remove the sand bars which had long obstructed the harbor at St. Louis. The Lees arrived the first of May and as their furniture had been blown up along with the boat carrying it, the Lees moved in with the Beaumonts.

By 1839, Beaumont who had always been of a serious and irascible temperament, had many problems to disturb him. An English edition of his *Observations* was to be published; he renewed his efforts to locate St. Martin; he was concerned about selecting an assistant, arguments within the medical society, bickerings with the Surgeon General's office over disbursements; and he also became disturbed over the possibility that he would be transferred back to Jefferson Barracks, as it appeared Zachary Taylor might be using his influence to have his son-in-law replace Beaumont in St. Louis.

Suddenly, without warning, came an order to report to a medical board convening in Florida. The order continued: "After adjournment of the Board, the officers composing it will report to the Commanding General in Florida for duty."

* * *

BEAUMONT IMMEDIATELY wrote to the Surgeon-General and the Adjutant General of the Army asking for a change in orders and making an alternative offer of his resignation. He had decided under any circumstances to remain in St. Louis. He wrote: ". . . I am told by some gossips from Washington that the Secretary talks about dropping me from the rolls if I don't obey the order. Let them do as they choose. They will only disgrace and injure themselves

and not me." On February 2, 1840, the acceptance of his resignation arrived.

William Beaumont continued an active and distinguished practice in St. Louis. In 1841, he was elected President of the Medical Society and to membership in the National Institution for the Promotion of Science.

Twelve years later, he slipped on icy steps and, as one of his biographers, Mrs. Max W. Myer[9] states: ". . . a month later he died of complications."

Mrs. Myer has reported in detail the St. Louis period of Beaumont's life, using letters and diaries of the family, and the episodes above are from her writing.

More recently, Estelle Brodman, Ph.D., Associate Professor of Medical History, Washington University, St. Louis, reported to the 1963 meeting of the American Association for the History of Medicine the important role played by Surgeon General Lovell in the preparation of the *Observations*. Doctor Brodman is reviewing the original Beaumont material collected by Dr. George Dock and given to the University Library.

* * *

WHEN ALEXIS ST. MARTIN died at 86 on June 24, 1880, Sir William Osler attempted to secure an autopsy. The family, however, refused. The body was kept at the home during warm weather to decompose and then buried in an unmarked grave in the cemetery of the Parish Church at St. Thomas, Quebec, to prevent exhumation.

In 1957, the Canadian Physiological Society appointed a committee, of which Dr. E. H. Bensley of Montreal was chairman, to seek ways and means of memorializing the grave of St. Martin. With the help of M. Gabriel Drouin, President, Institut Genealogique Drouin, Montreal and Paris, it was possible to trace descendants of St. Martin. Through personal contacts[6] by Dr. Eugene Robillard with the family, and with the assistance of French physicians of Montreal and the parish priest at St. Thomas, one of the granddaughters of St. Martin, who as a child had been present at the burial, was influenced to reveal the location of the grave.

The remains of Alexis are in a deep grave a few feet from a side window in the church, the window nearest the altar. On June 7, 1961, a group of Canadian scientists and historians met at the site of the grave and conducted a memorial service and placed a plaque on the wall of the church honoring the memory of the French Canadian voyageur without whom William Beaumont would not have been able to carry out his research.

The same year, a beautiful portrait of Beaumont, painted by Deane Keller of the College of Fine Arts of Yale University, and made possible by the generous contributions of the surgeons of Michigan, was presented by Alfred H. Whittaker, M.D., to the History section of the Hall of Fame of the International College of Surgeons in Chicago. The presentation ceremony was marked by the delivery of a paper by Dr. Chauncey Leake, Assistant Dean and Professor of Pharmacology of the College of Medicine of Ohio State University, evaluating the immense contribution of William Beaumont, M.D., to the annals of American medicine.[10]

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Where Socialism Leads

Ironically, socialism, which is claimed by its advocates to be a system to provide for the needs of everyone, actually leads not only to tyranny but to a progressive breakdown of production and, if persisted in, eventually to starvation and anarchy. Red China is currently following this path; Soviet Russia has borrowed a few ideas from capitalism on occasion to combat economic collapse and starvation. On the other hand, capitalism, which does not claim as its objective "doing good" for everyone, creates infinitely greater wealth for all to partake of and provides freedom for the individual, instead of slavery, while doing so.—SAMUEL AYRES III, M.D., Beverly Hills, California.

IN MEMORIAM

EARL P. BUNCE, M.D., 77, Trufant physician for 45 years prior to his 1958 retirement, died August 2, 1963.

A 1911 graduate of the Detroit College of Medicine, Doctor Bunce practiced with his father in Williamsburg before beginning practice in Trufant in 1913.

Doctor Bunce was a Life Member of the Michigan State Medical Society.

* * *

H. NEILL CALKINS, M.D., 63, former Detroit physician, died July 19, 1963, in Battle Creek, after a long illness. Doctor Calkins practiced medicine in Detroit for many years.

He enlisted in World War II as a captain in the Medical Corps, and trained American doctors for war services in this country. Later he served in Tinian and Saipan in the South Pacific and became ill following his return.

He was an Associate Member of the Michigan State Medical Society.

* * *

PETER H. DARPIN, M.D., 73, Detroit general practitioner for 37 years, died August 9, 1963.

A native of Armenia, Doctor Darpin came to this country in 1924. He received his medical degree from the University of Michigan in 1926 and practiced in Detroit from that time until his death. Doctor Darpin was on the staffs of Delray General, Highland Park, Detroit Memorial, Oakwood and Brent Hospitals.

He was a Life Member of the Michigan State Medical Society.

* * *

G. DAVID HOAG, M.D., 29, Hastings physician, was killed August 6, 1963, in a plane crash.

A 1958 graduate of the Wayne State University College of Medicine, Doctor Hoag interned at Blodgett Memorial Hospital, Grand Rapids, and served for two years as an Air Force flight surgeon. He practiced in Middleville before coming to Hastings in September, 1962.

* * *

WILLIAM S. O'DONNELL, M.D., 68, Wayne County General Hospital physician since 1958, died August 13, 1963.

A 1920 graduate of the University of Michigan Medical School, Doctor O'Donnell practiced in Ann Arbor from 1922 to 1925, in Detroit from 1925 to 1955, and was on the staff at Lapeer State Home and Training School from 1956-1957.

Doctor O'Donnell was a member of the Academy of Pediatrics, Pediatric and Infectious Disease Society and the Detroit Pediatric Society. He was a member of Nu Sigma Nu fraternity.

WALTER H. WINCHESTER, M.D., 88, Genesee County physician for more than 50 years, died August 19, 1963. A 1900 graduate of the College of Physicians and Surgeons of Columbia University, New York, Doctor Winchester interned at New York's Presbyterian Hospital. He practiced in Sheboygan, Wisconsin, before coming to Flint in 1909. In 1910 he became the County Physician for Genesee County. In 1961 he retired from this position to become medical superintendent of Walter Winchester Hospital, a county facility named for him.



Doctor Winchester was chosen in 1955 as "Michigan's Foremost Family Physician" by the Michigan State Medical Society. He was a Life Member of MSMS.

Doctor Winchester was a past president of the Genesee County Medical Society and the Flint Academy of Surgery. He was a former chief of staff of Hurley Hospital and Women's Hospital.

Warning re Interviewing Athletes

. . . it is apparent that the responsible physician must be perpetually aware of many unique factors in evaluating any athlete's clinical history, straightforward though it may seem at first glance. . . . The reason for this is obvious, in that the average athlete is not ill or in pain, and thus the doctor to whom he is giving the history represents, from his viewpoint, not one who can and wants to help him, but rather a very significant threat to his continued participation in his chosen sport. Consequently it is not surprising that athletes will distort, conceal, or even deny significant items in their past history, and, even more distressing, parents of athletes will aid and encourage such evasions. . . . Finally, it is not uncommon for an athlete to invent or magnify completely insignificant historical items in an attempt to establish grounds for sympathy . . . therewith creating an emotional crutch upon which he can fall back, should his ability be found wanting.—Isao Hirata, M.D., Team Physician, Yale University; at the Second New Haven County Conference on Athletic Injuries, Meriden, Conn.

* * *

Joins Blue Shield

Dale Nouse, former assistant city editor of the Detroit Free Press, has joined Michigan Hospital Service as assistant director of public relations.

Under the direction of Robert M. Hanson, MHS director of publications and advertising, Mr. Nouse will be in charge of press, radio and television relations for Blue Cross.

In his new post, Mr. Nouse will replace the late Henry H. Alexander.



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*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961.

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Say you saw it in the Journal of the Michigan State Medical Society

"Decisions" TV Program Moves to Noon Spot

Tens of thousands of Michigan residents will learn more about the professions when the weekly television program produced by the Michigan Association of the Professions shifts from its early morning spot to 12:30 p.m. each Sunday.

"This is a high compliment to the professions," declares George H. Cary, LL.B., MAP President. "We are grateful to WJBK-TV, Channel 2, Detroit, for this challenge. We shall continue to give freely of our knowledge in behalf of better public understanding of what the professions are accomplishing."

The program, "Decisions—The Moment of Truth," was formerly aired at 9:00 a.m. and built up an enviable audience. The 12:30 p.m. schedule went into effect September 29 for the new fall season.

Many of the weekly programs spotlight doctors of medicine—often teamed with pharmacists, veterinarians, dentists, pharmacists, educators, engineers, or architects.

MSMS members are invited to urge friends—especially young people who are contemplating a professional career—to view the informative program.

Coller-Penberthy Conference Successful; Plan for 1964

This year, the 43rd Annual Coller-Penberthy Medical Conference drew 236 registrants to Traverse City—and leaders are already looking forward to the 1964 event.

The conference is always the last Thursday and Friday in July and anyone interested in receiving advanced notification and a copy of the program may write to the Secretary, Grand Traverse-Leelanau-Benzie County Medical Society, James Decker Munson Hospital, Traverse City.

Featured speaker at the Friday evening banquet was Roger W. Heyns, Vice-President for Academic Affairs of the University of Michigan, on "Higher Education Today." Remarks then were added by Clarence I. Owen, M.D., President of MSMS; William N. Hubbard, Jr., M.D., Dean, U-M Medical School, and Albert G. Furstenberg, M.D., Dean Emeritus, U-M Medical School.

The outstanding array of scientific speakers included the following from Wayne State—Richard J. Bing, M.D.; G. Thomas McKean, M.D., and Edgar E. Martmer, M.D.; the following from the U-M—Walter P. Work, M.D.; Arthur C. Curtis, M.D.; A. James French,



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M.D.; Edgar Kahn, M.D.; Harry A. Towsley, M.D.; Norman F. Miller, M.D.; Isadore Lampe, M.D., and Reed M. Nesbit, M.D. Also on the program were Lester R. Dragstedt, University of Florida; Charles B. Huggins, M.D., University of Chicago, and E. H. Ellison, M.D., University of Marquette.

Presiding officers for the various activities were Frederick A. Coller, M.D.; Edwin L. Thirlby, M.D., and Harry L. Weitz, M.D., all of Traverse City.

This conference was originated by Doctors Coller and Thirlby 43 years ago, and soon after the late Doctor Grover C. Penberthy joined to help provide outstanding speakers.

Physicians from Midwest To Confer in Detroit

More than 100 physicians will be on the scientific program of the American College of Physicians' Midwest Sectional Meeting, November 21-23 in Detroit.

Following the general format of the College's Annual Meeting, the Sectional Meeting will consist of general clinical sessions, combined clinical investigation and basic science sessions, panel discussions and symposium.

Plans for the meeting are under the direction of Wesley W. Spink, M.D., Minneapolis, President of the American College of Physicians and Professor of Medicine. James T. Howell, M.D., Detroit, is Chairman of the Local Committee on Arrangements.

The program November 21 will consist of symposia on upper gastrointestinal hemorrhage and pulmonary disease problems. Symposia on cardiac arrhythmias and interpretation of antibody response in disease are scheduled for November 22. Concluding sessions are on endocarditis and cerebrovascular disease.

Hospital Representatives Confer With U-M Senior Medical Students

Thirty-four Michigan hospitals sent representatives to The University of Michigan Medical School this fall for the second annual Hospital-Internship Day. The event enabled physicians from Michigan hospitals to discuss their institutions' internship programs with the 175 members of the U-M Medical School's senior class.

In all, 104 doctors attended the event, some coming from such distant points as the James D. Munson Hospital in Traverse City, Hackley Hospital in Muskegon and Little Traverse Hospital in Petoskey.

This was the second annual such event for the U-M Medcal School and C. J. Tupper, M.D., Associate Dean, said he feels that "the program was of major

(Continued on Page 1022)



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Hospital Representatives Confer With U-M Senior Medical Students

(Continued from Page 1020)

benefit both to the Michigan hospitals represented and to our senior medical students." Also speaking at the event was Richard Erbe, president of the class of 1964.

Wayne State Joins Temporal Bone Bank

Wayne State University's College of Medicine has become the 25th medical center to join a nationwide program concentrating on ear research by joining the Temporal Bone Banks Program, announced Dr. Gordon H. Scott, dean of the College of Medicine.

The program is sponsored by the American Academy of Ophthalmology and Otolaryngology and by the Deafness Research Foundation, a volunteer organization formed four years ago to investigate causes of deafness.

Wayne is one of the three in Michigan now processing temporal bones. Others are at Henry Ford Hospital and the University of Michigan.

U-M Medical School Steps Up Counseling

The University of Michigan Medical School has established a new program of student counseling and has named three of its faculty members to serve in the capacity of counselors in addition to their regular duties. Appointed were Drs. John R. G. Gosling, Dorin L. Hinerman and Henry H. Swain.

Efforts will be concentrated on the freshman and sophomore medical school classes, the levels at which students most frequently encounter difficulty.

Common Cold Causes School Absences in Michigan

The common cold continues to be the largest single factor contributing to the 14.2 days per school year the average Michigan student is absent from school, according to a study by Schering Corporation.

The study, using statistics from the National Education Association, reveals that Michigan ranks 11th in best attendance records. The best record for 1962-63 was Washington with an average of 10.5 days missed. Utah was second with 11.2. The national average of school absences was 18.9.

Medical surveys indicate that children of elementary school age have five times as many colds as do adults.

(Continued on Page 1024)

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'Emprazil-C' Tablets are available on prescription only.

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Common Cold Causes School Absences

(Continued from Page 1022)

According to a 1963 U.S. Public Health Service report, respiratory illnesses were responsible for about two-thirds of school days lost because of acute illnesses or injuries during the 1961-62 school year.

The first onslaught of colds strikes the schools almost as soon as children reassemble for the new year. One contributing factor is that spread of colds like other virus-caused infections is accelerated by the mixing of populations. In fixed stable groups which are not exposed to strangers, cold-like infections tend to die out, and do not reappear until there is contact outside the group.

Demonstrates U. S. Methods At India Medical School

Medical schools in India may soon break away from traditional British methods of teaching anatomy and adopt the more streamlined United States approach.

If they do, it will be due in great measure to Russell T. Woodburne, M.D., chairman of The University of Michigan Medical School's department of anatomy. Doctor Woodburne spent more than a month at India medical schools this summer under joint assignment from the All-India Medical Council and the U. S. State Department Agency for International Development.

The demonstration visit, during which Dr. Woodburne gave part of an anatomy course in the fashion in which the material is presented here, was suggested by Dr. M. Wharton Young, who took his Ph.D. degree from the U-M anatomy department and who is now medical advisor at the medical college in Trivandrum, India.

In addition to teaching students, Doctor Woodburne met with Indian professors of anatomy daily, discussing problems with them.

Conference on Thyroid Offered at Kalamazoo

Bronson Methodist Hospital, Kalamazoo, Michigan, will hold its Annual Clinical Conference October 16 on "Diseases of the Thyroid and Parathyroid Glands." The Conference will consist of several individual addresses, plus case presentations and panel discussions. Guest speakers are as follows: Richard E. Weeks, M.D., Internal Medicine, Mayo Clinic; Austin L. Vickery, M.D., Pathology, Massachusetts General Hospital; Brown M. Dobyns, M.D., Professor of Surgery, Western Reserve University; and Willard P. Vanderlaan, M.D., Endocrinology, Scripps Clinic and Research Foundation.

The AMA Department Of International Health

By R. W. Teed, M.D.

Ann Arbor, Michigan

From the time that Dr. David Livingstone went to Africa in 1841, and Dr. Hudson Taylor went to China in 1853, North American and European physicians have been carrying the healing art to all parts of the world. The majority of these have been missionaries, dedicated to the Gospel as well as to Medicine, although there have been many others who went out for purely humanitarian reasons.

In 1946, in Chicago, a group of physicians incorporated the Christian Medical Society, which at present numbers over 3000 Christian physician members plus about 2000 medical and dental students. Approximately 500 members are serving in mission hospitals in 95 countries. Since 1956, the Society has been forwarding drugs and medical equipment, donated by American Manufacturers, to its members all over the world. In 1962, over $2,500,000 worth (wholesale) of material was thus distributed.

Since 1958, the Society has been sponsoring "short-term missionaries"—members who go voluntarily at their own expense to some area of need outside the United States and serve for periods of time varying from one to six months in an established mission hospital. During this interval, several dozens of physician members have cooperated in this program, which is continuing.

In August, 1960, in Chicago, the Executive Director of the Society met with a committee of the AMA to discuss a program relating to medical missionary enterprise abroad. This program was further discussed at a meeting in New York in November. Out of this discussion came, in 1961, the organization of the AMA Department of International Health, the purpose of which is (1) to define the role of the AMA in the area of International Health, (2) to review past, current and projected activities in this field; (3) to promote mutual cooperation with various voluntary and governmental agencies; and (4) to ascertain how American Medicine can assume a larger role in solving world health problems. Participants include medical schools, medical directors of business corporations with hospital facilities abroad; governmental and intergovernmental agencies; pharmaceutical companies; voluntary organizations; individual physicians who have worked abroad for long periods at a grass roots level; organizations with drug and medical equipment collection programs; and miscellaneous organizations having interests in international health.

The objectives of the Department are: (1) to establish the AMA as a clearinghouse and repository for foreign medical information; (2) to serve as a non-governmental coordinating agency in inter-



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national health activities; and (3) to furnish information on international health to any member of the AMA, especially those going abroad. Much of the information gathered appears in the "AMA News" and the "Journal AMA," but more is available on request.

AMA representatives have been designated to approximately 30 International Congresses and foreign national medical society meetings, and it is anticipated that eventually there will be as many as 200 such designees. Priorities for selection are from officers of the AMA, its affiliated Societies and AMA members who are officers, speakers or attendants at Congresses.

Inquiries regarding overseas employment have been received from nearly 400 physicians during the past year, indicating the upsurge of physician interest in this activity. While some sponsoring organizations are able to pay transportation costs, unfortunately the majority of medical missionary organizations cannot afford this. However, many of these, as well as the Christian Medical Society, will accept tax-exempt gifts by which transportation may be purchased. There are also a number of small groups of physicians in this country, who keep one of their number in a foreign medical mission hospital most or all of the time, in which the income from the group is regularly split between all members of the group.

The Department of International Health has identified 46 voluntary non-profit organizations which collect medical equipment, drugs, supplies, journals and textbooks for overseas shipment, and will soon issue a handbook on this activity for distribution to state and county medical societies, Woman's Auxiliaries, Medical News Media and others.

The department, in association with state, county and Metropolitan hospitality centers, has initiated programs for visiting foreign physicians, which include visits to medical institutions and to homes of U. S. physicians. Similar programs are planned for foreign physicians and students who are studying for extended periods in the U. S. Also, lists have been compiled of English-speaking physicians in many foreign countries who are willing to host U. S. physicians in their homes.

The Department has attempted to aid Cuban physicians seeking employment or practice in the U. S., and has referred to them inquiries by U. S. physicians seeking to employ Cuban physicians. The department also cooperated with the U. S. government, American Red Cross, and other organizations in the negotiations leading to the exchange of the Bay of Pigs prisoners of war.

The department has coordinated efforts to furnish simple, basic public health information scripts to broadcasting companies covering Central and South America, Far East (including Red China), Middle East

(Continued on Page 1028)



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The AMA Department Of International Health

(Continued from Page 1026)

and Africa. Materials have been supplied on such subjects as personal hygiene, immunizations, prenatal and maternity care, food inspection, nutrition, accident prevention, alcoholism, first aid, tropical diseases, care of burns, eye care, etc.

Foreign medical schools, libraries, hospitals, ministers of health, et cetera, have been supplied with summaries of scientific articles, information on nutrition, quackery, legislative proposals, health information, et cetera, with a more ambitious program planned. Other areas are also being studied with a view to even wider medical contribution and cooperation. Through these means, the AMA is becoming a most important factor in World Health Programs.

AMA Clinical Meeting Beckons to Portland

More than 4,000 physicians and their guests will converge on Portland, Oregon, for the 17th Clinical Meeting of the American Medical Association, December 1-4. Nearly all of the scientific sessions will be held in Portland's new Memorial Coliseum.

Lectures, panels, symposia and breakfast roundtables again will be presented at the Portland meeting on selected topics. Color television and motion pictures also will be utilized.

More than 100 physicians will deliver lectures on the scientific program during the four-day meeting, and more than 200 scientific and industrial exhibits will be shown at the Coliseum, many of which will be based on new scientific research.

An outstanding feature of the Clinical Meeting will be a symposium on "Genes, Chromosomes and Immune Mechanisms," December 2. Other specific topics will include immunization, with special emphasis on the viruses; cancer of the breast; kidney problems, including the newest thoughts on kidney acid-base control; heart and blood vessel surgery; the practical clinical approach to anticoagulants; trauma as it relates to everyday noises; smoking in relation to mortality and morbidity; and causes of death in automobile accidents.

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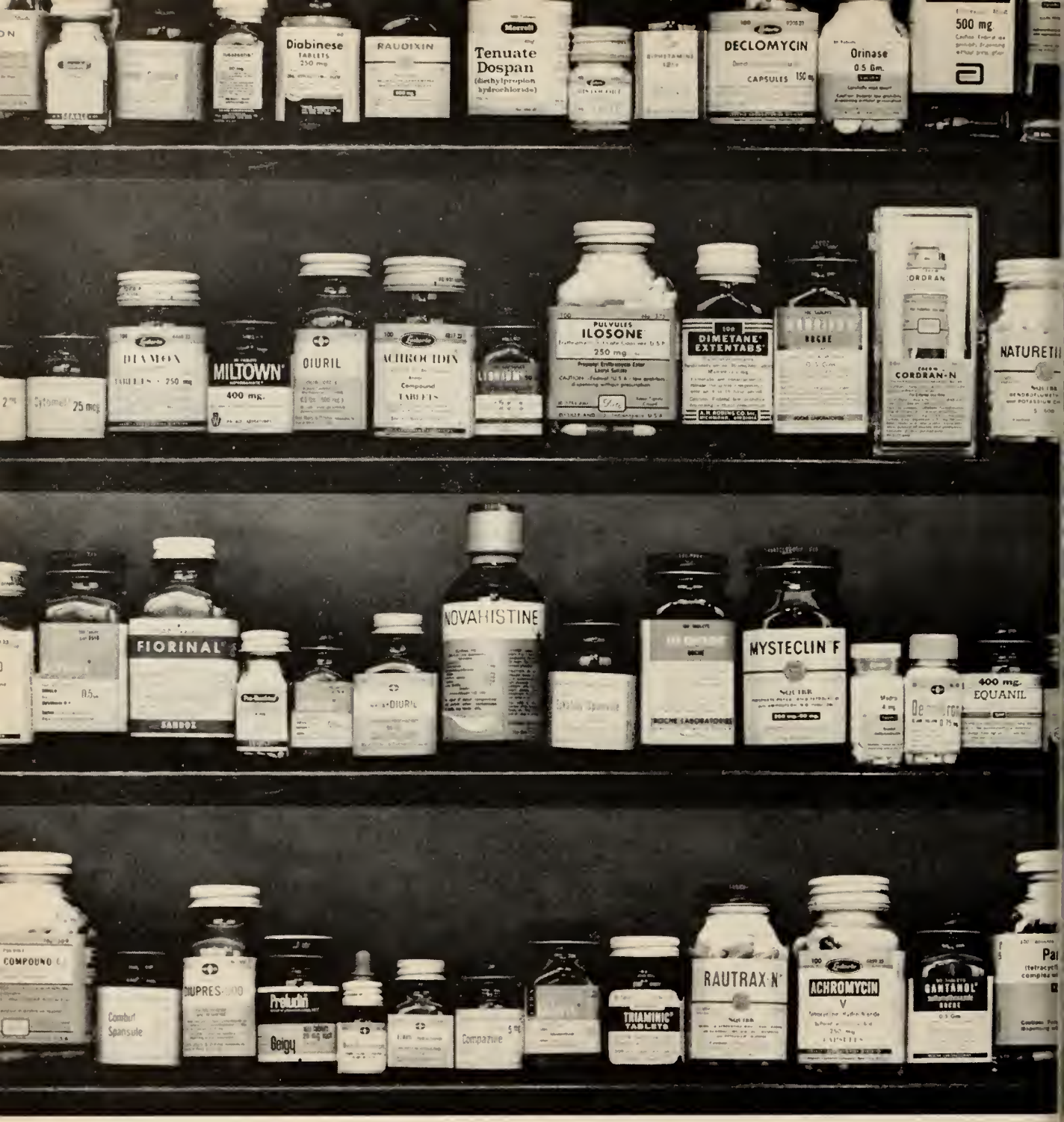
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We made a list of the most frequently prescribed drugs of 1962. We gathered them together to take the picture you see on this page. Then we eliminated all products introduced more than 10 years ago. *But then, for the camera to make the labels legible, it became necessary to eliminate several more.*

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News—To the Point

FETED BY COMMUNITY—A grateful community paid its respects recently to William Rae Young, M.D., of Lawton, for his 50 years of service. Speakers at the event, held at the Methodist Church, pointed out that Doctor Young had served Lawton since 1913, that he was a past president of both the Van Buren and Kalamazoo county medical societies, and that he served as a delegate many years to the MSMS House of Delegates.

* * *

LEADER IN EDUCATION—Robert K. Whiteley, M.D., Grosse Pointe, was elected recently as president of the Grosse Pointe Board of Education.

* * *

LEAVES ISHPEMING—Douglas W. Erickson, M.D., at Ishpeming since 1956, has joined the Cancer Memorial Foundation at Santa Barbara, California, as an associate in the practice of radiation therapy and nuclear medicine.

* * *

DISCUSSES CANCER—Michael J. Brennan, M.D., of Detroit, addressed the Midtown Kiwanis Club of Grand Rapids on Monday, September 23, on "Avoidable Causes of Cancer." His talk was sponsored by the Michigan Cancer Coordinating Committee.

* * *

MORE M.D. PLACEMENTS—Recent locations reported by the M.D. Placement Service of the Michigan Health Council are: Peter F. Nowosielski, M.D. (Livonia); Rateb K. Homsi, M.D. (Cheboygan); Roger J. Smith, M.D. (Allegan); John H. Lignell, M.D. (Charlevoix); Ellsworth E. Klahr, M.D. (Frankfort).

* * *

SPEAKER—Robert W. Talley, M.D., Detroit, gave the President's Address at the 12th Annual Meeting of the Michigan Association for Retarded Children. Doctor Talley was succeeded by Richard Johnston, Kalamazoo, as president.

* * *

COMES TO MICHIGAN—Harry O. Ingberg, M.D., has joined the staff of the Rehabilitation Institute, Detroit. A graduate of the Medical School at Cincinnati University, Doctor Ingberg completed his physical medicine and rehabilitation residency at University Hospital at Columbus.

* * *

SPEAKS IN WEST—Max K. Newman, M.D., Detroit, recently participated in the program of the Third International Conference of the Joint Council to Improve the Health Care of the Aged in San Francisco.



DOCTOR WALLS MOVING WEST—Arch Walls, M.D., of Detroit, who served as president of MSMS in 1956-57, has retired from practice. Doctor Walls soon will make his home in Kalispell, Montana.

* * *

RETIRES—The retirement of Raymond G. Colyer, M.D., plant physician of the Fisher Body Detroit Central plants, has been announced by Fisher Body Division of General Motors. After a two-year internship at Harper Hospital, he joined Fisher Body in 1926, as physician for the Detroit Central plants with offices at Plant No. 35 in Detroit. In 1939, he moved to the Die and Machine plant where the Detroit Central plant medical facility was relocated. He has been with GM for 37 years.

* * *

GIVES PAPER—The relationship of anxiety and psychosomatic disease—particularly the allergic manifestations—was the subject of a paper delivered by M. J. Steinhardt, M.D., Detroit, at the recent meeting of The American College of Allergists in New York.

* * *

LEAVES WSU—George O. Clifford, M.D., associate professor of medicine at Wayne State University, has accepted the position as chief of hematology at Memorial Hospital Sloan-Kettering Institute in New York City.

APPOINTED—Frederick C. Swartz, M.D., Lansing, has been appointed to serve on the Employment Task Force of the State of Michigan Commission on Aging. The Commission "seeks to develop a 10-year plan for more adequate services, facilities and opportunities for aging and aged in Michigan."

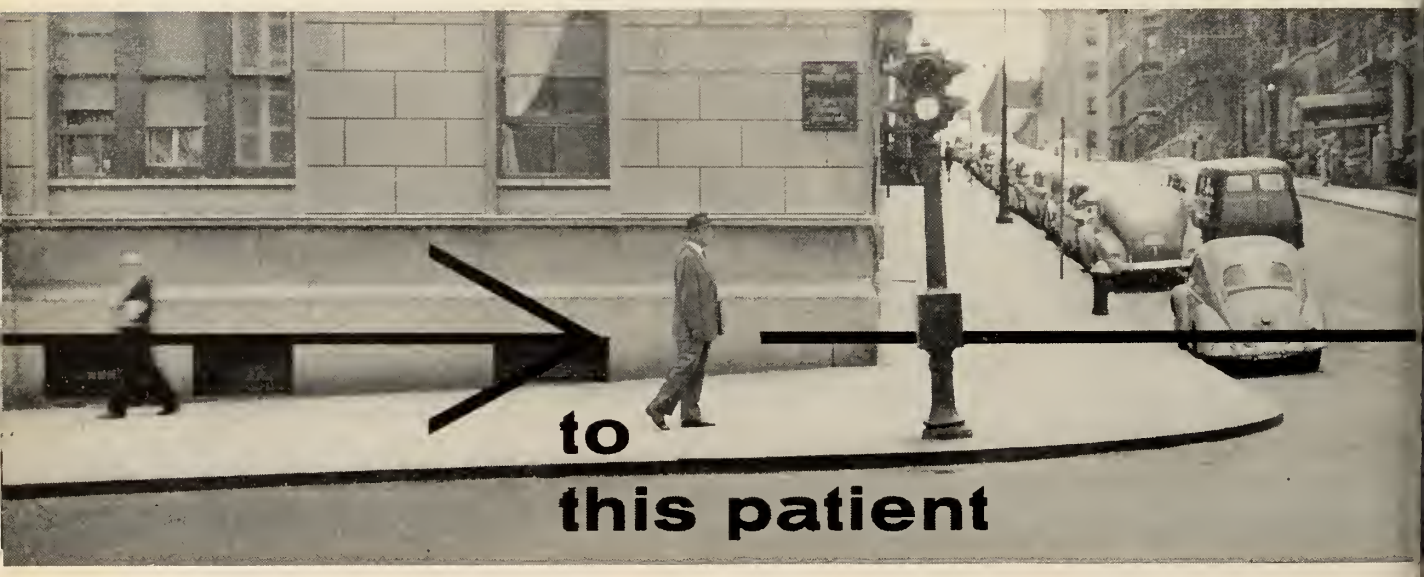
* * *

BLOOD BANK MEETING—Blood bank experts from across the nation will come to Detroit November 5-8 for the 16th Annual Meeting of the American Association of Blood Banks. Prominent among the Michigan leaders will be Rosser L. Mainwaring, M.D., Dearborn, President-Elect; Lawrence W. Gardner and Avis M. Olson, M.D., Detroit, Co-Chairmen of the Committee on Local Arrangements, and Julius Rutzky, M.D., Pontiac, Technical Program Chairman.

* * *

APPOINTED—W. C. C. Cole, Sr., M.D., Detroit, has been appointed to the State Department of Social Welfare's Medical Advisory Committee. The letter of appointment indicated that "the areas of mutual responsibility are going to be more meaningful in the future."

Doctor Cole was recommended by The MSMS Council.



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MICHIGAN MEDICAL MEETINGS

Kalamazoo Bronson Methodist Hospital Annual Clinical Conference, October 16, Kalamazoo.

Hospital Section of Michigan Library Association, October 18, Bancroft Hotel, Saginaw.

Alumni Conference Michigan Medical Center, October 18-19, Ann Arbor.

American College of Obstetricians and Gynecologists, District V, October 24, 25, 26, Statler Hilton Hotel, Detroit.

South Central Michigan Clinic Day October 24, Battle Creek.

Michigan Tuberculosis and Respiratory Disease Association and Michigan Thoracic Society, Annual Meeting, October 24, Kellogg Center, Michigan State University. East Lansing.

Genesee County Medical Society Diabetes Day, November 6, Hurley Hospital.

Michigan Academy of General Practice, 17th Annual Fall Postgraduate Clinic, November 13-14, Sheraton-Cadillac Hotel, Detroit.

American College of Physicians' Midwest Sectional Meeting, November 21-23, Sheraton-Cadillac Hotel, Detroit.

Canadian-American Medical and Dental Ski Association, February 17-19, Harbor Highland, Harbor Springs.

USA CALENDAR

American Academy of Dermatology, Palmer House, Chicago, Nov. 30-Dec. 5. Sec.-Treas.: Stanley E. Huff, M.D., 636 Church St., Evanston, Ill.

American Association of Blood Banks, Statler Hilton Hotel, Detroit, Nov. 5-8. Sec.: E. Arthur Dreskin, M.D., 11 Summer St., Greenville, S. C.

American College of Obstetricians and Gynecologists (District 6), Schroeder Hotel, Milwaukee, Nov. 20-23 Sec.-Treas.: Harold A. Kaminetzky, M.D., 1853 W. Polk, Chicago 12.

American College of Physicians (sectional meeting), Detroit, Nov. 21-23. Exec. Dir.: Edward C. Rosenow, Jr., M.D., 4200 Pine St., Philadelphia 4.

American Medical Association (Clinical Meeting), Memorial Coliseum, Portland, Ore., Dec. 1-4. Exec. Vice-Pres.: F. J. L. Blasingame, M.D., 535 N. Dearborn, Chicago 10.

National Conference on Medical Aspects of Sports (fifth) Portland, Ore., Dec. 1. AMA Health Education Dept., 535 N. Dearborn, Chicago 10.

American Academy of Occupational Medicine, Statler Hilton Hotel, Hartford, Conn., Feb. 5-7. Sec.: Gordon M. Hemmett, M.D., 343 State St., Rochester, N. Y.



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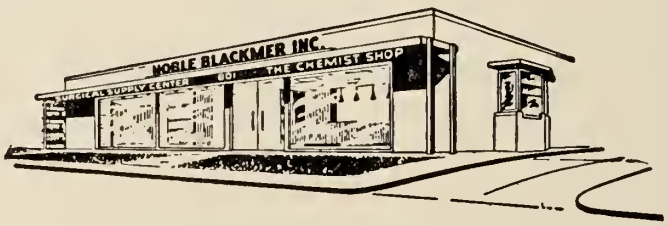
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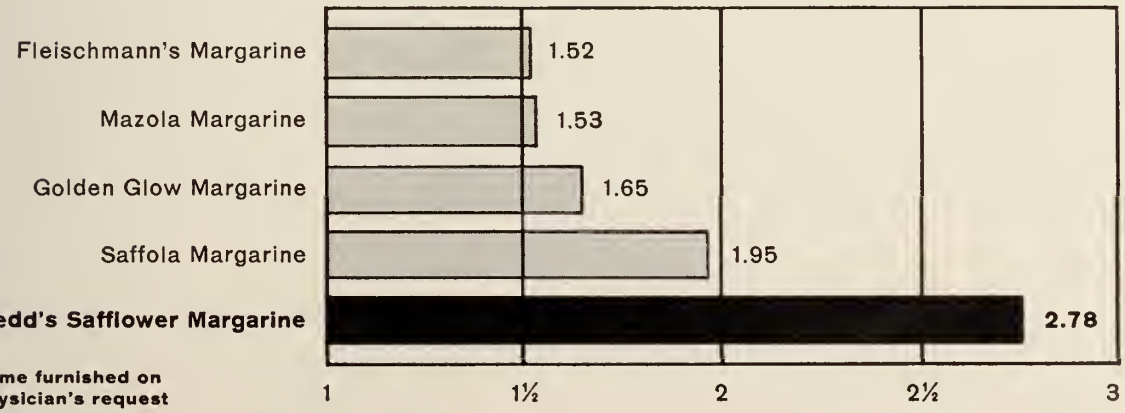


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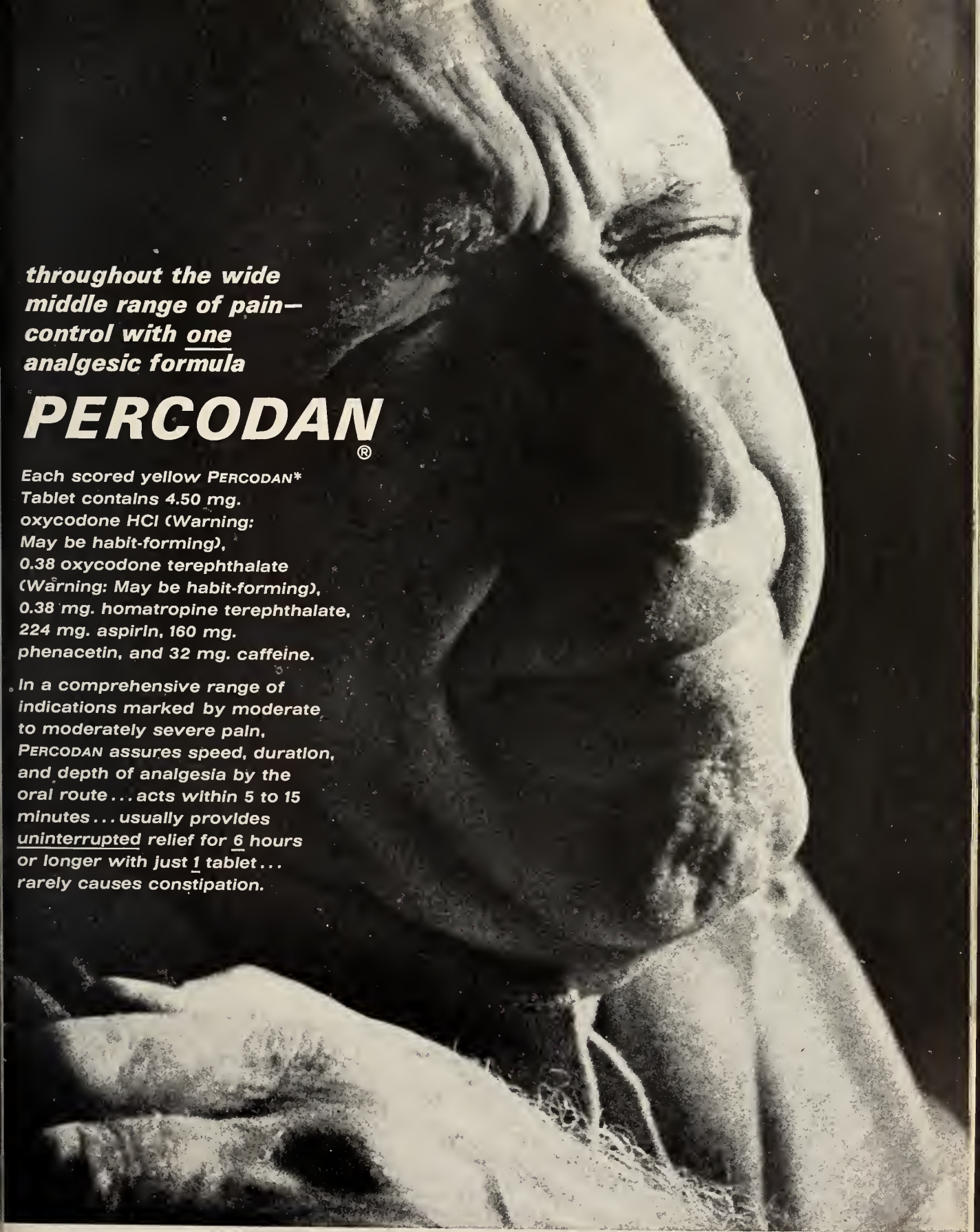
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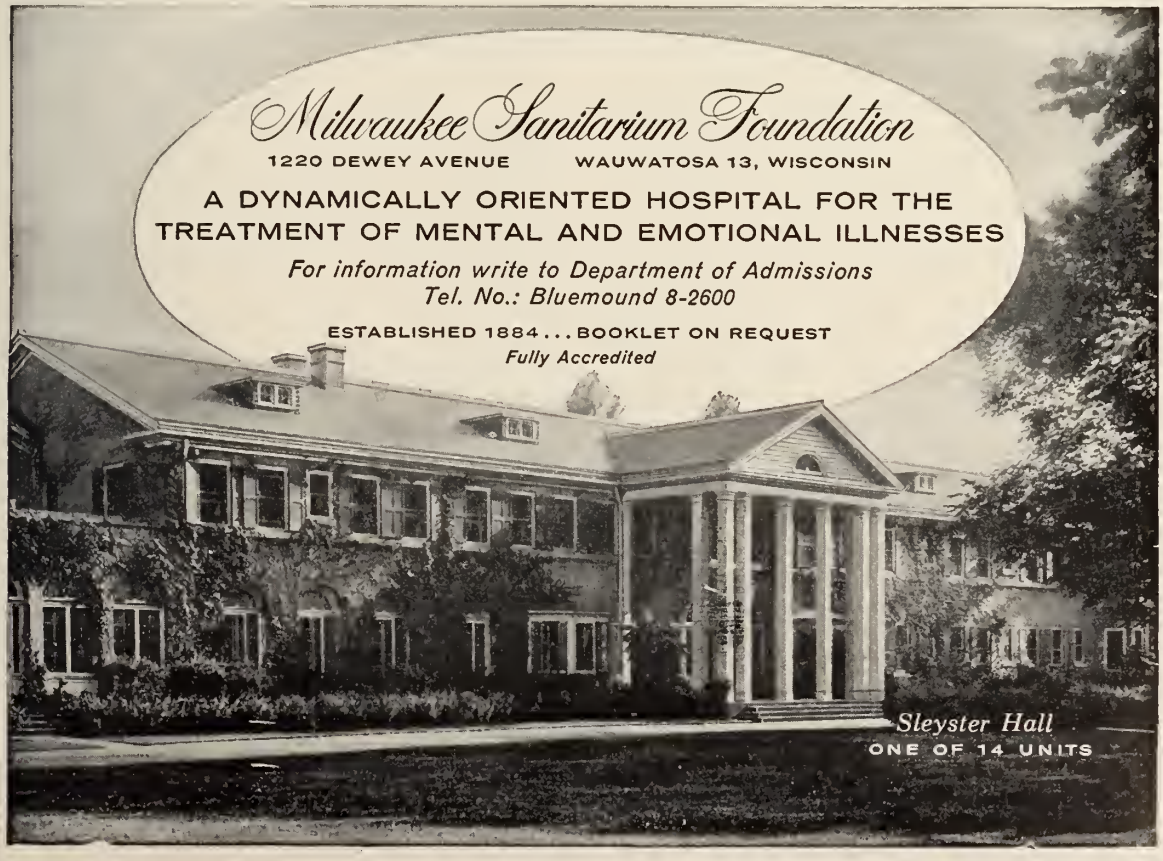
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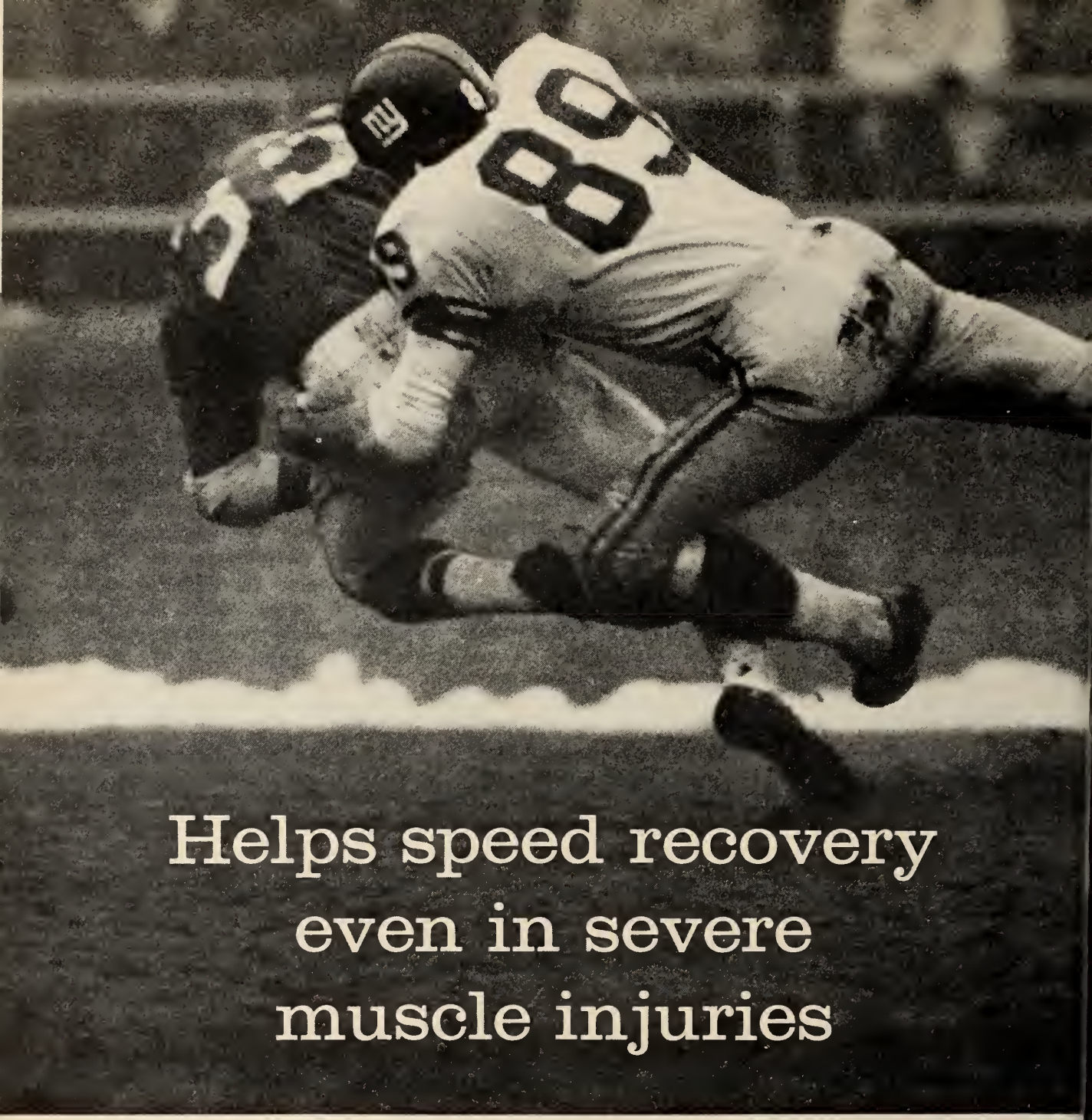
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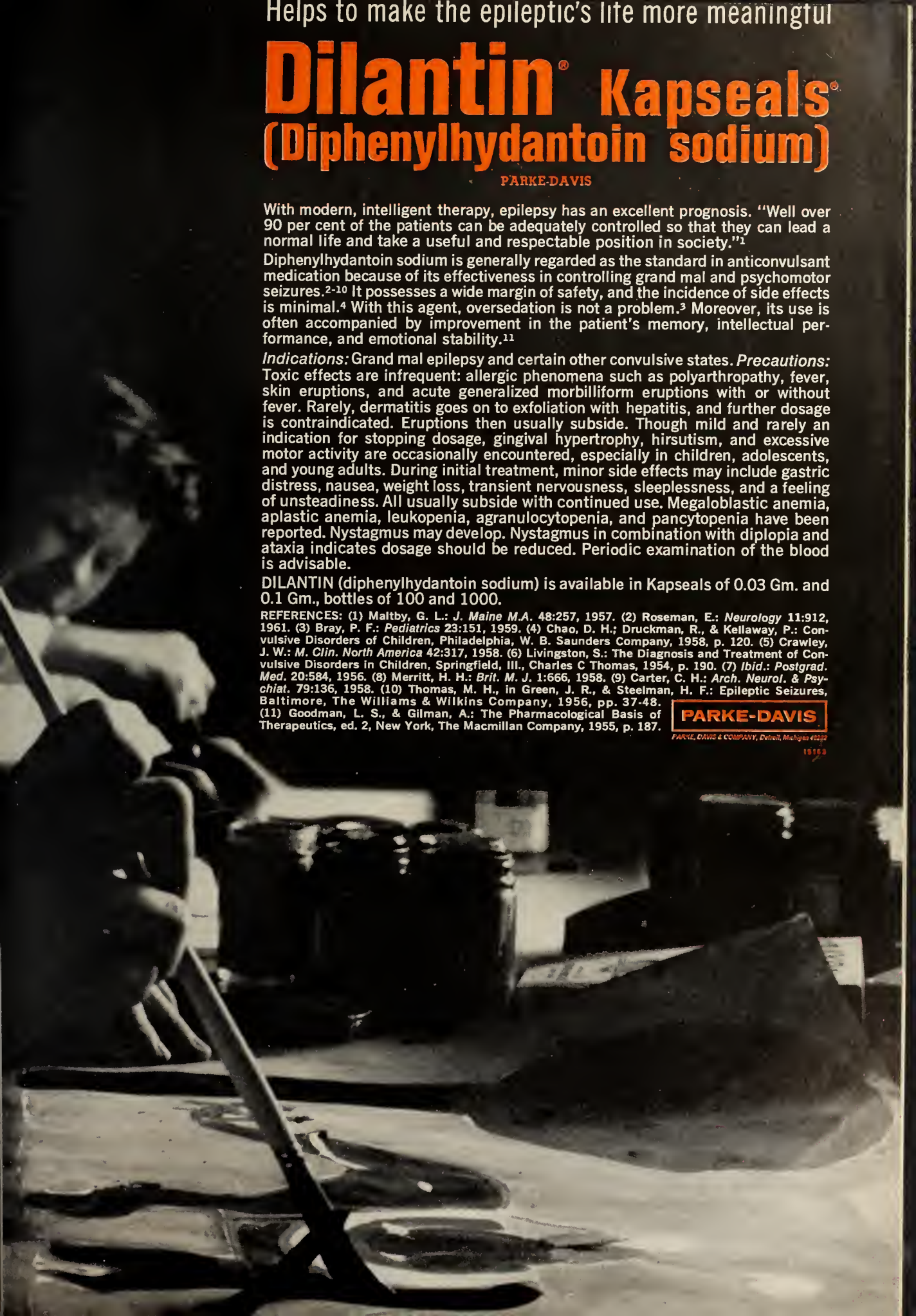
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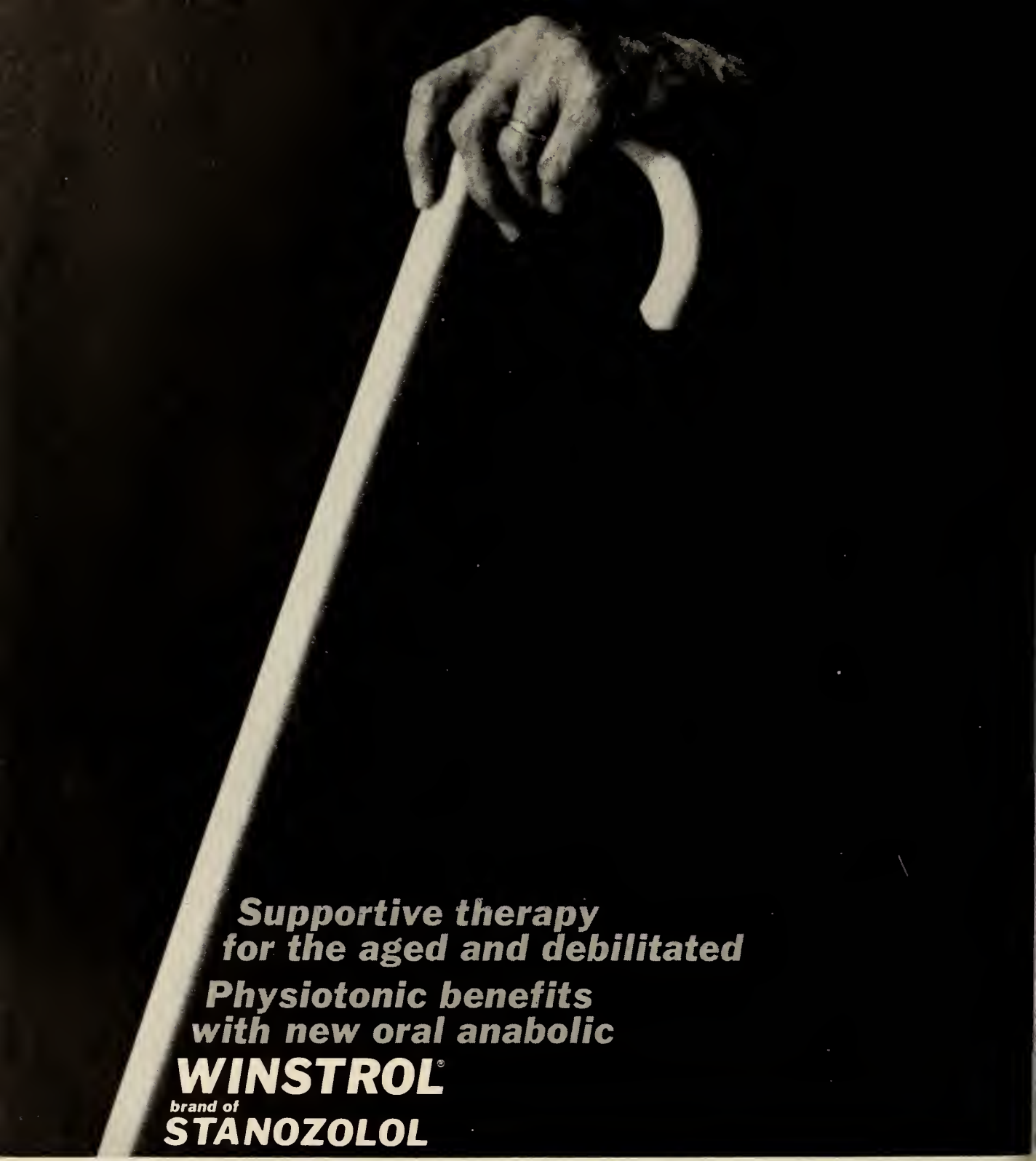
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REFERENCES: (1) Maltby, G. L.: *J. Maine M.A.* 48:257, 1957. (2) Roseman, E.: *Neurology* 11:912, 1961. (3) Bray, P. F.: *Pediatrics* 23:151, 1959. (4) Chao, D. H.; Druckman, R., & Kellaway, P.: Convulsive Disorders of Children, Philadelphia, W. B. Saunders Company, 1958, p. 120. (5) Crawley, J. W.: *M. Clin. North America* 42:317, 1958. (6) Livingston, S.: The Diagnosis and Treatment of Convulsive Disorders in Children, Springfield, Ill., Charles C Thomas, 1954, p. 190. (7) *Ibid.*: *Postgrad. Med.* 20:584, 1956. (8) Merritt, H. H.: *Brit. M. J.* 1:666, 1958. (9) Carter, C. H.: *Arch. Neurol. & Psychiat.* 79:136, 1958. (10) Thomas, M. H., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48. (11) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.

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DELEGATES TO A. M. A.

Delegates

	Term Expires
J. R. Heidenreich, M.D., Daggett	1963
W. A. Hyland, M.D., *Chairman*, Grand Rapids	1963
O. J. Johnson, M.D., Bay City	1963
L. R. Leader, M.D., Birmingham	1963
C. I. Owen, M.D., Detroit	1964
G. W. Slagle, M.D., Battle Creek	1964
D. N. Sweeny, Jr., M.D., Detroit	1964

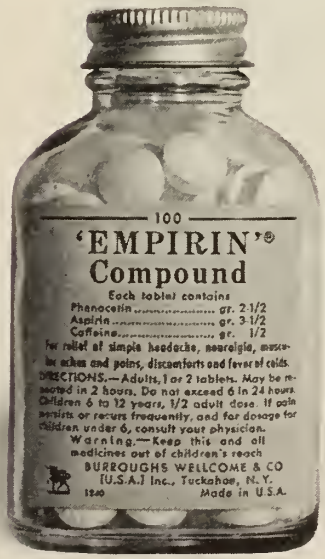
Alternates

	Term Expires
G. B. Saltonstall, M.D., Charlevoix	1963
J. M. Wellman, M.D., Lansing	1963
Sidney Adler, M.D., Detroit	1963
B. M. Harris, M.D., Ypsilanti	1963
R. E. Rice, M.D., Greenville	1964
A. Hazen Price, M.D., Detroit	1964
E. E. Martmer, M.D., Grosse Pte	1964



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President's Page

WHEN YOU TELL, BE SURE TO SELL



Allen J. Johnson M.D.

President
Michigan State Medical Society

One thing that a physician, all physicians, can do is "sell" modern medical care. By sell, I mean, making the public aware of how inexpensive is the type of care they are getting. The fundamental proposition is that today's medical care was not available twenty or twelve years ago. Antibiotics, cobalt, cortisone, or heart surgery were not to be had.

The long economic drain of tuberculosis has been dramatically reduced by early detection and antibiotics and chemotherapy. "Polio" is rapidly becoming non-existent. Surgery for thyrotoxicosis is at a minimum. The death rate, complications and long recovery period from pneumonia are near eradication.

Only 40 years ago, one in every four patients who were subject to a major operation died. Now one in every 100 dies and many operations are performed that were impossible 10 years ago. The heart lung machine makes possible delicate heart operations. Thousands of people formerly died from a ruptured appendix. These people recover today. Today, one out of every three cancer patients survive, whereas, in 1931 only one out of seven survived. New drugs, new vaccines and new techniques have developed so rapidly—80% of those now used were not known 10 years ago.

The average prescription cost today is $3.91. In 1939, it was 91 cents but today's drugs couldn't be bought in 1939. The average wage earner works 18 minutes less today to buy these drugs. The length of time a person is ill or hospitalized is much less, so the cost of being ill or for hospitalization is often much less—an important economic factor.

While the total cost of health care has risen rapidly the cost of physicians services has not. Hospital costs have increased the most but of the average hospital bill 70 per cent is for labor. Labor costs in hospitals have increased 520 per cent since 1946. According to the Bureau of Labor Statistics, physician fees went up 95 per cent from 1940 to 1960; food 150 per cent, shoes 175 per cent and men's hair cuts jumped 233 per cent. Per Capita incomes rose nearly 200 per cent more than doctor's fees.

The caliber of medical education in the United States is so high in quality that nearly 9,000 foreign students are now studying medicine in this country.

In the first 13 years of socialized medicine in England that country built only one new hospital while the United States has built 763. In those years America has produced 19 Nobel prize winners in medicine, while England has had four. It used to be about equal.

This is part of the Story of American Medicine, that money couldn't buy twenty or twelve years ago. This is the part of the story physicians must tell.

With Americans knowing this story the propaganda, subterfuge and half truths of socializers and politicians will fall on deaf ears.

Activities Focus Interest On Special Health Week



Co-sponsored by the Michigan State Medical Society, the Michigan Health Council and the Michigan Association of the Professions, "The First Annual Michigan Community Health Week" was successfully launched in October.

State-wide attention was directed to the Week by a Proclamation signed by Governor George Romney.

The proclamation read:

"Nothing is more essential and necessary to the growth and progress of our state among the 50 states than the good health, welfare and safety of our citizens. Dramatic advances in modern medical science during the past few decades have resulted in a considerable reduction in the number of many dread diseases and made happy healthy community living more a reality than a dream.

"Communities—large and small—throughout the state have undertaken intensive educational programs for the protection of their citizens of all ages, and state groups and associations have contributed importantly to furthering these necessary health protection programs. Assisting the state and the communities are some of the finest medical schools in the nation located in Michigan and the research services and products rendered by pharmaceutical firms which call Michigan their home.

"Citizen concern for their good health and the health of the state as a whole is all important if we are to achieve the success we seek as one of the nation's greatest and most prosperous states.

"Therefore, I, George Romney, Governor of the State of Michigan, do hereby proclaim the week of October 20, 1963, as Community Health Week in Michigan, and call upon the Michigan Health Council, the Michigan State Medical Society, the Michigan Association of the Professions, and all other organizations with a major interest in the health of our citizens to join in this observance to demonstrate the importance of good health on a community level."

In addition to the proclamation, Governor Romney and Mrs. Romney served as honorary Co-Chairmen of Community Health Week.

During the week numerous television and radio programs were devoted to Community Health Week. General Chairman Joseph R. Lentini, M.D., of Grand Rapids, and Co-Chairman Mrs. Robert Hermanson of Dearborn, Health Chairman of the Michigan Congress of Parents and Teachers, took part in a 15-minute telecast on WJBK-TV. Additional telecasts were produced by WZZM-TV Channel 13, Grand Rapids; WWTV-Channel 9, Cadillac. Other television stations had news spot announcements frequently during the week urging families to have their youngsters immunized, to purchase and use seats belts when driving, to avoid spending money needlessly on quackery, and other special Community Health Week projects.

The Michigan Farm Bureau taped radio messages by Mrs. Hermanson, Hugh Brenneman of the Michigan State Medical Society and John A. Doherty of the Michigan Health Council and these were sent to radio stations throughout Michigan by the Farm Bureau.

Numerous daily and weekly newspapers devoted space to editorials and news stories about Community Health Week.

A special "Health Career Week" was held in Niles at the local hospital to generate interest in medicine and other health careers. Several hundred young people took part in a "Career" night program at Howell High School. The Muskegon County Medical Society and Hackley Hospital joined to tell 400 county students about "Medical Careers" at a Saturday program.

This Michigan version of the AMA Community Health Week will be expanded further in 1965.



Robert T. Osterlund presents a watch to Wm. J. Burns (with Mrs. Burns watching) as a token of appreciation from the Medical Exhibitors Association. Mr. Osterlund flew from Florida to attend the MSMS Annual Dinner and to make the presentation.

MSMS Shows Appreciation To Wm. J. Burns at Annual Session

The Michigan State Medical Society at its Annual Session in Grand Rapids said "thank you" to William J. Burns, East Lansing, retiring executive director.

Exactly 911 doctors of medicine, their wives and special guests attended a tribute dinner at the Grand Rapids Civic Auditorium.

Highlight of the event was the surprise presentation of a new automobile to Mr. and Mrs. Burns. And it was an even greater surprise when their daughter, Miss Missy Burns, of Washington, D. C., hopped out of the car to give the key to her father. The Medical Society had flown her to Grand Rapids for the surprise ceremony.



Wm. J. Burns voices his appreciation to Oliver B. McGillicuddy, M.D., MSMS President-Elect, for a book of letters received from MSMS members and friends lauding Mr. Burns for his outstanding service. Doctor McGillicuddy made the presentation at the Annual Dinner.

The 1963 MSMS House of Delegates unanimously voted a resolution reminding the membership that "Mr. Burns has devoted his considerable talents and boundless energy for 29 years to the operation of the MSMS organizational structure."

The resolution further stated that "MSMS and Michigan Medicine has grown during these 29 years and due credit should be extended to Mr. Burns." A large bronze plaque was presented to Bill Burns during the House's final meeting of September 24.

A special gift notebook of letters was presented to Mr. Burns at the banquet of September 26 by Oliver B. McGillicuddy, M.D., Lansing, MSMS President-Elect. More than 500 letters had been addressed by doctors and others to Mr. Burns attesting his many contributions to Medicine and the health of the state.

Mr. Burns will retire from the MSMS post December 31 to go in business for himself! He will enter the field of medical and professional convention and exhibition management. Mr. Burns will serve half a dozen national organizations in the health field.

Honor Two Employees

Two MSMS employees were honored by the 1963 House of Delegates as part of an authorized program to recognize years of service.

This year, the Delegates applauded the presentation of a 20-year award to Miss Helen A. Schulte and a 15-year award to Robert J. Roney.

The 1961 House of Delegates authorized awards to employees based on length of faithful service.

TYPICAL REMINISCING BY MSMS 50-YEAR HONOREES

"I Have Tried to Write My Name Deep In the Hearts of Patients and Friends"

(The following letter is typical of the comments made by the MSMS members who received their coveted 50-Year Pins at the 1963 Annual Session. This letter is from E. W. Caster, M.D., now of Oak Park)

"I give this account of my personal life because it gives some light on the practice of medicine at the turn of the century. It was quite different from the present.

"I guess I am a maverick. I was never much interested in making money, except as necessity required. My big object in life was to live it to the full, to realize it from different angles and experiences. Above all, I wanted to make my life full of service to others. Because of this I felt that the ministry was my best calling.

"Three years at Albion College, (a grand institution) and I longed to find out if the University of Michigan looked at life from a different angle. It did. Every place where I have lived has had a different characteristic. I took my senior year at the U. of M. graduating from the Literary Department in 1903.

"Then followed four years of Theological training, together with the pastorate of a church in Detroit. There was an old-fashioned saloon right across the corner. I was stressing the social side of Christ's teaching. I wanted to form Men's Clubs, Women's Circles, and Youth groups. My superiors informed me that that was just social work. I was supposed to preach religion.

"From my childhood my IDOL had always been the old-fashioned family physician. He was not only the conservor of their physical well being, but he was also their friend and counselor. So I resigned from the church and started to study medicine, 1907. I gained my Doctorate in Medicine in 1911, from Wayne State University College of Medicine.

"My first patient, even before I opened an office, was a neighbor's dog. He lived. I kept track of referrals from that family, until I had collected over $1,000. That was big money then, with office calls at fifty-cents and house calls at $1.00. Night calls $2.00. Confinements were $10.00. My office cost me $18.00 a month rent. Later I paid $125.00 for the same office.

"(When I was a sophomore, I took a doctor's practice, one summer, for ten weeks, while he was away studying for a Specialty.)

"I early cut out surgery and G.U. work as I did not like them. I loved General Practice and O.B. I much prefer home calls to office practice. The further away the call the better as I love to drive. My greatest pleasure is to sit down by the bedside and not only attend to one's physical troubles but to inspire the patient to a new realization of the joy of living.

"I had seen Highland Park's population grow from 1,800 to 65,000. I had had a part in the forming of the beginning of the high school. I was on the committee that planned the Highland Park General Hospital. While studying Medicine, I had helped form the Highland Park Congregational Church, and was their first minister for two years. I have since been honored with the title of Pastor Emeritus. But I longed for the open spaces.

"I left Highland Park in 1927 and moved to Yale, a small town up in the thumb. We were very happy there until the depression of the 1930s struck us. Then I lost everything that I had, my city property and our beautiful big home in Yale. I would have been on the welfare but for the help of a good sister and brother-in-law. Farmers had been getting $7.50 for one hundred pounds of beans. The price dropped to $.75. I could not collect anything.

"I positively would not ask credit from anyone so long as I had no prospect of repayment. I went out and sawed logs with a farmer, taking home some of the wood to burn in a stove in one room of our house.

"I heard of a doctor in Mt. Clemens who had had to quit on account of his health. We moved there and took over his office. I got a greater thrill of starting all over again, than I did the first time. Built up the largest practice I ever had. I believe I would be dead now if I had continued the pace.

"But the Second World War was on. I got an invitation to go up to Flint to the Buick and take charge of the physical examinations of the new employees. We put on 16,000 new help while I was there. I had no night calls. WHAT A LUXURY.

"My experience at the Buick was most interesting and rewarding. I had never been on the inside of a

big corporation before. The Union was riding high, wide, and handsome. No matter what a person did, the Labor Board always decided in favor of the individual. I really saw human nature. The 4 p.m. to midnight shift had the whole hour from seven to eight to take their lunch, play cards, watch television or listen to speakers. I was often asked to speak. The Union leaders were standing around just waiting for me to say something that they could find fault with. The Company foremen were fearful that I would go off the deep end. Fortunately I avoided the shoals of both sides and stayed in the middle of the stream. I managed to keep in the good graces of both management and labor.

"When I went there I asked what were the chances of staying. I was told that 'Buick would always need doctors.' But after the war was over I found that General Motors don't keep employees who are age 65. I was fired. Then the order was rescinded. I was told to stay. But I saw the handwriting on the wall and gave them thirty days notice.

"I had an offer from a doctor in Detroit to take his place while he went to Florida for six months. Then I could have a vacation of six months with full pay. It looked too good to be true. It was. I found out that he advertised. I stopped it until he returned. When he came back and started it again, I quit.

"Our children asked if I intended to get an office and practice again. I said 'NO, an office would tie me down, Uncle Sam would take a share and you kids would spend the rest; Mother and I are going to take it easy and travel some more.' We have crossed the continent at least four times by auto. We have covered a good share of the United States and much of Canada. Can't remember how many times we have gone to Florida and back. One time we went down there and back twice in five weeks.

"It is interesting to muse on the difference in the practice of medicine now and when I began. One of my early patients turned out to be an old childhood friend. He had pneumonia. The only way we could give him oxygen was to put his head as close to an open window as possible. When he died, it cut deep into my soul. Our class had the first course in X-ray given by the school. All it was good for was to see if we had set broken bones properly. We speculated a good deal on other uses it might be good for.

"I am not the type to write my name high in the annals of Medicine, but I have tried to write it deep in the hearts of patients and friends. If I had my life to live over again I don't believe that I would change it much. My wife is 83 and I am 84. As we travel down the pathway toward the sunset of life, we both feel that we have filled our niche in life. What more could we ask?

"I love my confreres. They are a noble bunch. It has been a great pleasure to be one of them."

—E. W. Caster, M.D.
24711 Ridgedale
Oak Park, Michigan

29 MSMS Members Get Coveted 50-Year Pins

Twenty-nine men who have each practiced 50 years or more were honored at the MSMS Annual Session.

The "50-Year Pin" was awarded to the following:

Alpena-Alcona-Presque Isle:
Charles S. Wilson, M.D., Alpena

Genesee:
Leon M. Bogart, M.D., Flint
Guy D. Briggs, M.D., Flint
Elisha W. Caster, M.D., Oak Park
Grant Thorburn, M.D., Waynesboro, Pa.

Grand Traverse-Leelanau-Benzie:
Fred G. Swartz, M.D., Traverse City

Houghton-Baraga-Keweenaw:
Raymond E. Hillmer, M.D., Painesdale

Ingham:
Maurice L. Richardson, M.D., Lansing

Ionia-Montcalm:
O. P. Geib, M.D., Gaylord
Isaac S. Lilly, M.D., Stanton

Kalamazoo:
William Huyser, M.D., Kalamazoo
Roy A. Morter, M.D., Kalamazoo

Macomb:
Milton C. Smith, M.D., Mt. Clemens

Oakland:
Frank B. Gerls, M.D., Pontiac

St. Clair:
Dorsey W. Patterson, M.D., Port Huron

Van Buren:
William Rae Young, M.D., Lawton

Washtenaw:
Frederick A. Coller, M.D., Ann Arbor

Wayne:
Clarence L. Candler, M.D., Detroit
Lowry C. M. Conley, M.D., Detroit
Howard Havers, M.D., Detroit
Charles S. Kennedy, M.D., Detroit
Gordon S. McAlpine, M.D., Detroit
William R. McClure, M.D., Boynton Beach, Florida
Robert C. Moehlig, M.D., Detroit
Harold L. Morris, M.D., Detroit
William D. Ryan, M.D., Detroit
Ernest C. Schultz, M.D., Detroit
F. Janney Smith, M.D., Grosse Pointe Farms
Harold F. Ohrt, M.D., Detroit

(Turn to Page 1054)

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MSMS Annual Session Photos



At Left—As his last official act, C. I. Owen, M.D., installs O. J. Johnson, M.D., Bay City, as the new president of the Michigan State Medical Society.



At Right—Congratulations are exchanged after the House of Delegates re-elected James J. Lightbody, M.D., right, Detroit, as Speaker of the House of Delegates, and chose Oliver B. McGillicuddy, M.D., Lansing, as President-Elect of MSMS.

Below—Wm. J. Burns and his wife try out the new car after it was presented by MSMS at the Annual Dinner Dance. AMA and MSMS leaders admiring the car are left to right, Harold H. Hiscock, M.D., new Chairman of The Council; Clarence I. Owen, M.D., MSMS Past President; Edward R. Annis, M.D., AMA President; O. J. Johnson, M.D., MSMS President; and James J. Lightbody, M.D., Speaker of the House of Delegates.





Above—Edward R. Annis, M.D., second from left, AMA President and Annual Dinner Dance speaker, is met at the Grand Rapids airport by a MSMS delegation. Left to right are Wm. A. Hyland, M.D., Grand Rapids, Delegate to AMA; Carl B. Beeman, M.D., President of Kent County Medical Society; Joseph R. Lentini, M.D., Grand Rapids, member of MSMS Annual Session News Committee; and Frederick C. Brace, M.D., Grand Rapids, former college classmate of Dr. Annis at Marquette University.



At Right—A moment of joy is shared by two of the recipients of the MSMS Certificates of Commendation. Left to right are Forest D. Dodrill, M.D., Bloomfield Hills, and John M. Sheldon, M.D., Ann Arbor. (See article on Page 1064 for details about the four recipients).

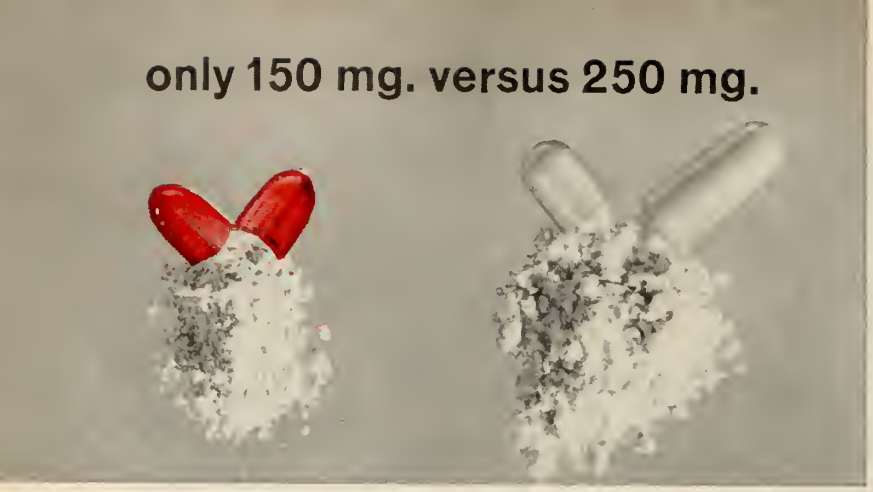
Below—A MSMS Certificate of Commendation is presented by MSMS President O. J. Johnson, M.D., to Charles J. Jentgen, M.D., right, Detroit.



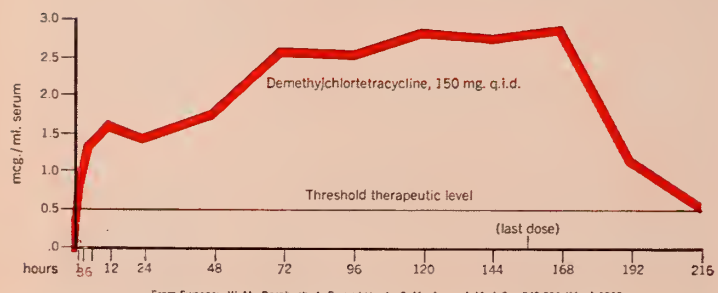


Homer H. Stryker, M.D., Kalamazoo, was unable personally to receive his Certificate of Commendation because he was speaking to an international medical meeting in Europe.

only 150 mg. versus 250 mg.

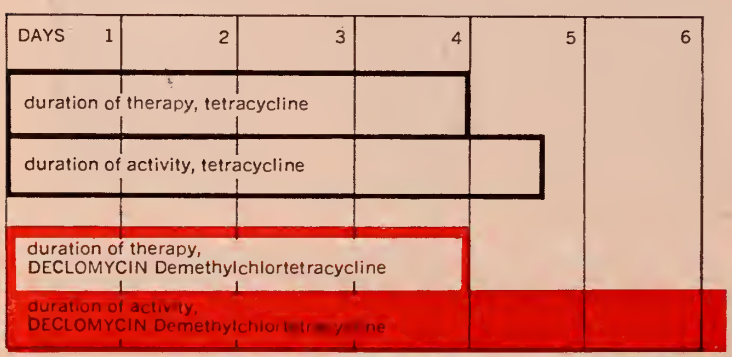


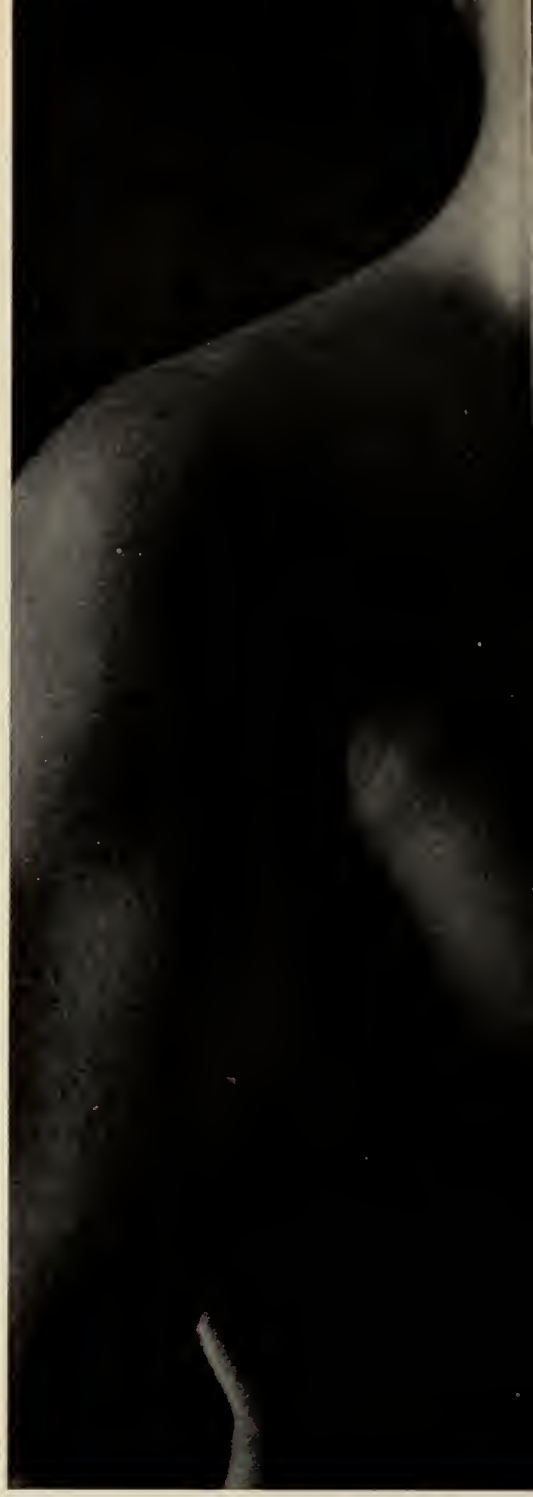
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From Sweeney, W. M., Dornbush, A. C., and Hardy, S. M. *Amer. J. Med. Sci.* 243,296 (Mar.) 1962.

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HIGHLIGHTS of The Council

Meetings of September 22 and 26, 1963

Many important items were considered by The Council at its two meetings held coincident with the MSMS Annual Session in Grand Rapids. Chief in importance were the following matters.

- Consideration of County Societies Committee recommendation re AMA position on public health. The Council adopted an amended motion of the Committee that the attention of the MSMS Delegation to the AMA House of Delegates be invited to the Concept of Public Health adopted by the AMA in November, 1962, and requesting clarification and better definition of some of the terms contained in Item 3 which describes the role of public health.
- The Michigan Health Officers Association, by letter, expressed thanks to MSMS for sponsoring a reception at the MHOA meeting in Cadillac on August 23.
- The Council approved an invitation for MSMS to co-sponsor with the Michigan Department of Health a Conference on Diet Therapy to be held in late January or early February of 1964.
- The Council was informed that the Statement of Principles Governing Hospitals, Doctors and Lawyers had been approved by the State Bar of Michigan and the Michigan Hospital Association. The MSMS Council had approved this at a previous meeting. The Council authorized sharing the expense of publishing this statement with the Bar Association and the Hospital Association, in addition to referring the Statement to the Journal Editor for possible publication in The JOURNAL MSMS.
- As authorized by the Constitution and Bylaws, amended by the House of Delegates in 1962, many of the duties of the Secretary of MSMS were transferred to the Executive Director.
- Regarding the recommendations of the Iodized Salt Committee for an educational campaign, The Council requested further information regarding specific cost estimates so that The Council could give more adequate study to the proposal.
- Correspondence from the Michigan Hospital Association expressed appreciation for the valuable time and sound advice contributed by Mr. Hugh W. Brenneman during the past year as a member of the Committee on Public Relations of MHA.
- Questions regarding the Medicare contract and fee schedule were referred to the appropriate committee which negotiated the present Medicare fee schedule, for study and report.
- Legal Counsel reported on opinions regarding partnership liability, right of health officer and proper method of handling charges of unethical practice.
- The Executive Director's Report reviewed the activities of the staff during the previous two months.
- Public Relations Counsel's Report reviewed attendance at meetings, time change for television program and Public Relations Committee recommendations.
- Council Chairman McGillicuddy reported that MSMS had been requested to nominate a physician for appointment to the Medical Advisory Committee to Michigan Hospital Service for a term ending in 1966, to replace O. J. Johnson, M.D., who is unable to serve.
- The following appointments were announced: Assistant MSMS Historian, Wm. M. LeFevre, M.D., Muskegon; Medical Advisory Committee to Department of Social Welfare, W. C. C. Cole, Sr., M.D., Detroit (to fill vacancy left by Doctor Haughey's death); Ex Officio Member, Board of Directors, Michigan Association of Health, Physical Education and Recreation, James S. Feurig, M.D., East Lansing; and MSMS Chairman, Community Health Week, J. R. Lentini, M.D., Grand Rapids.
- The Council authorized Louis E. Heideman, M.D., Detroit, to attend the AMA National Conference on Physicians and Schools, October 10-12, Chicago, as MSMS representative; also G. L. Otis, M.D., Jackson, to attend as MSMS representative the Medical Society-AMA Disaster Conference, November 2-3, Chicago.
- The Council heard a progress report regarding the repeal of Rule 10 by the Board of Social Welfare. The effective date of repeal is now July 1, 1964.
- Michigan Medical Service President Sidney Adler, M.D., shared with members of The Council the contents of the Supplementary Report of Michigan Medical Service which was to be presented to the 1963 MSMS House of Delegates.
- Committee Reports. The following were given consideration:

 (a) Medical Care Insurance Committee, meetings of August 7, August 21, and September 8, 1963. These reports reviewed committee interviews with representatives of other organizations regarding

(Continued on Page 1061)



winter coughs ahead...
clear the tract with Robitussin®

ROBITUSSIN®
Each 5 cc. tsp. contains:
Glyceryl guaiacolate 100 mg.

ROBITUSSIN® A-C
Robitussin with antihistamine and codeine.
Each 5 cc. tsp. contains:
Glyceryl guaiacolate 100 mg.
Pheniramine maleate 7.5 mg.
Codeine phosphate 10 mg.
(exempt narcotic)

Photo: N. & W. Engine No. 611, last of the famous "Class J" locomotives, on its final run between Roanoke, Va., and Williamson, W. Va., Oct. 26, 1959.



For the coughing patient who labors to remove tenacious mucus from his respiratory tract, Robitussin provides a remarkably potent expectorant action. It contains glyceryl guaiacolate which increases respiratory tract fluid (R.T.F.) almost 200% to "clear the tract" of cough-inducing irritants. Increased R.T.F. also permits more efficient action of bronchial and tracheal cilia to further enhance the evacuation of sputum, thus reducing cough frequency and helping the cough remove its cause.

After more than thirteen years and millions of prescriptions, no serious side effects have been reported from Robitussin. And patient acceptance has been outstanding.

A. H. ROBINS COMPANY, INC., Richmond 20, Virginia

This is the season Allbee® with C is made for!



When a good old-fashioned winter proves too much for your modern-day patients, it's a comfort to know about Allbee with C. Consider its simple, rational, economical formula when patients need therapeutic amounts of B and C vitamins during the "flu" and u.r.i. season. **This is what Allbee with C is made of:** Thiamine mononitrate (B_1), 15 mg.; Riboflavin (B_2), 10 mg.; Pyridoxine HCl (B_6), 5 mg.; Nicotinamide, 50 mg.; Calcium pantothenate, 10 mg.; Ascorbic acid (vitamin C), 300 mg.

A. H. Robins, Co., Inc. Richmond 20, Va.

HIGHLIGHTS OF COUNCIL MEETING

(Continued from Page 1058)

Michigan Medical Service and contained progress reports on the developments of drafts of the Annual Report of the Committee.

(b) Supplemental Annual Report of the Medical Care Insurance Committee, 1962-63. Two proposed drafts were considered by The Council and referred to an ad hoc study committee which reported out an amended version which was adopted by The Council. This report was then referred to the House of Delegates.

(c) Mental Health Committee, meeting of September 5, 1963. These minutes reported on the success of the State-County Medical Society Mental Health Conference, reviewed the Department of Mental Health under the new Constitution and the status of the Department of Health planning projects and implementation of state community mental health services legislation.

(d) Occupational Health Committee, meeting of September 10, 1963. These minutes contained recommendations concerning resolution on small plant medical services and a recommendation on preparation of standard disability forms.

(e) Postgraduate Medical Education Committee, meeting of July 18, 1963. These minutes reviewed the success of the Spring 1963 extramural program and contained suggestions for the Fall 1963 program.

(f) Publication Committee, meeting of August 15, reviewed reports of the Editor, report on backlog of scientific articles and discussion of various production details of The JOURNAL.

(g) Committee on Arrangements for 1964 Michigan Clinical Institute meeting of July 31, outlined the block systems to be used at the 1964 MCI, improvements and innovations, and suggestions to Program Committee for speakers and subjects.

(h) Committee on Courses on Medical Economics and Ethics, meeting of August 11, reviewed the 1962-63 Annual Report of the Committee and made extensive suggestions for the 1963-64 program.

(i) Hospital Relations Committee, meeting of August 14. These minutes had to do with a code of procedures and ethics relating to autopsies, Michigan Hospital Association policy re questionnaires to member hospitals and physician membership on hospital governing boards, and proposed new pharmacy rules and regulations.

The Council adopted a motion containing an alternate suggestion to one of the controversial rules proposed in the new pharmacy rules and regulations. Action on the complete committee minutes was deferred due to this action of The Council. At the request of this Committee, the House of Delegates was requested by The Council to restudy 1962 House Resolution No. 40.

(j) Liaison Committee with Michigan State Pharmaceutical Association, meeting of August 22. These minutes had to do with prescription labelling, refilling procedures, and physician-pharmacist code of understanding. These minutes were referred back to Committee for restudy and report.

(k) Public Relations Committee, meeting of August 29. These minutes reviewed the status of the proposed medical radio network, plans for the 1964 County Secretaries-Public Relations Seminar, high school debate topic, Community Health Week and other items of public relations interest. These minutes were approved.

(l) Health Fair Arrangements Committee, meeting of August 27. These minutes contained recommendations for the implementation of the Michigan Health Fair and Don W. McLean, M.D., General Chairman of Arrangements for the Health Fair, reviewed the Committee's presentation to be made to the 1963 House of Delegates. The Council concurred in the recommendations of the Committee and referred this matter to the 1963 House of Delegates for consideration.

(m) Committee on Professional Insurance Plans, meeting of September 11. Because of the technical nature of these minutes, consideration was postponed to a later time to provide more study and review of background material.

(n) Michigan Cancer Coordinating Committee, meeting of August 15. These minutes were received and Item 7 regarding legislation was referred to the Legal Affairs and Cancer Control Committees.

- The Supplemental Report of The Council was reviewed and amended to reflect actions of The Council taken at this meeting.
- Reorganization of The Council. At its Thursday meeting, September 26, the following officers of The Council were elected: Chairman—Harold H. Hiscock, M.D., Flint; Vice-Chairman—Robert J. Mason, M.D., Birmingham; Chairman of Finance Committee—C. Allen Payne, M.D., Grand Rapids; Chairman of County Societies Committee—Edgar E. Martmer, M.D., Grosse Pointe; Chairman of Publication Committee—Wm. A. Scott, M.D., Kalamazoo.
- The Committee on Coordination of Medical Meetings during the Centennial Year, meeting of September 24, was reported by Chairman O. J. Johnson, M.D., and it was noted that agreement had been reached with the Michigan Academy of General Practice Board of Trustees that the Academy

(Continued on Page 1064)

The one tranquilizer that

BELONGS IN EVERY PRACTICE

it's versatile: The years have proved that 'Miltown' (meprobamate) is the one tranquilizer that is helpful in almost every aspect of daily practice. Virtually any of your patients, regardless of age, can be given the drug with confidence, either as a primary treatment or as an adjunct to other therapy. **Outstanding record of safety:** Over eight years of clinical use among millions of patients throughout the world — plus more than 1500 published reports covering the use of the drug in almost every field of medicine — support your prescriptions for 'Miltown' (meprobamate). This is why it *"belongs in every practice."*

dependable: 'Miltown' (meprobamate) is an established drug. There are no surprises in store for you or your patient. You can depend on it to help your patients through periods of emotional distress — and to help maintain their emotional stability.

easy to use: Because 'Miltown' (meprobamate) is compatible with almost any other kind of drug therapy, you'll find it fits in easily with any program of treatment you are now using. It will not, therefore, complicate treatment of patients seen in clinical practice.

BRIEF SUMMARY: *Indications:* Anxiety and tension states, and all conditions in which anxiety and tension are symptoms. *Side Effects:* Slight drowsiness may occur and, rarely, allergic or idiosyncratic reactions, generally developing after 1-4 doses of the drug. *Contraindications:* Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. *Precautions:* Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities, to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available to physicians on request.*

USUAL ADULT DOSAGE: 1 or 2 400 mg. tablets t.i.d.

SUPPLIED: 400 mg. scored tablets, 200 mg. coated tablets.

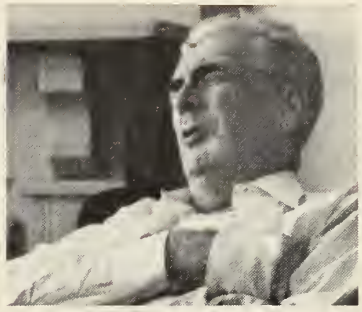
CM-9694



The insomniac



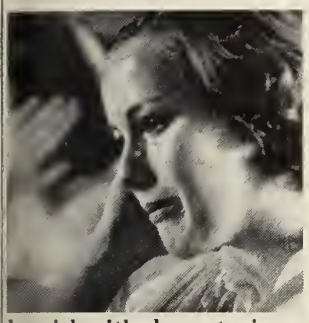
The tense, nervous patient



The heart-disease patient



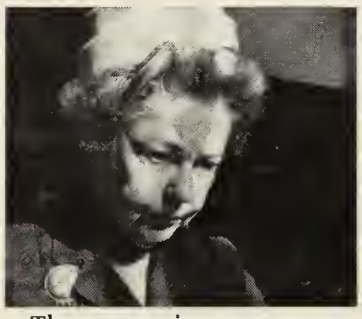
The surgical patient



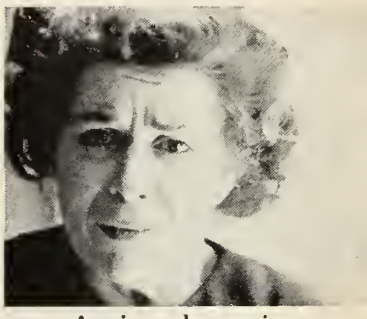
he girl with dermatosis



Tension headache



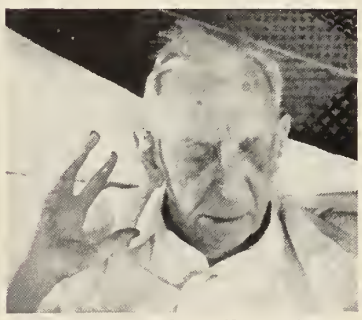
The woman in menopause



Anxious depression



Premenstrual tension



The agitated senile patient



The alcoholic



The problem child

the original brand of meprobamate

Miltown®



The G.I. patient

WALLACE LABORATORIES
Cranbury, N.J.

HIGHLIGHTS OF COUNCIL MEETING

(Continued from Page 1061)

would hold no meeting in 1965 if they could cooperate in the program of the MSMS Annual Session in such a way that their members would receive adequate credit for attendance. The Committee recommended that the MCI be discontinued after 1964.

- Speaker James J. Lightbody, M.D., reviewed matters referred to The Council by the 1963 House of Delegates and reported that the official transcript of the House of Delegates actions would be available for the November 20 meeting of The Council.

 Speaker Lightbody also evaluated the House of Delegates facilities and arrangements and made some constructive criticisms of the physical arrangements for the House of Delegates meetings.
- A briefing session for new members of The Council was announced by Chairman Hiscock, immediately following this meeting of The Council. New members of The Council were officially greeted with standing applause. Introduction of newly-elected officers: Vice-Chairman Hiscock introduced O. B. McGillicuddy, M.D., President-Elect; James J. Lightbody, M.D., Speaker; Louis F. Hayes, M.D., Vice-Speaker; Councilors W. C. C. Cole, Sr., M.D.; E. J. Tallant, M.D.; R. K. Whiteley, M.D., R. V. Taylor, M.D.; H. C. Hansen, M.D.; B. L. Masters, M.D.; Harold Kessler, M.D.; J. R. Dehlin, M.D.; D. R. Smith, M.D.; R. V. Daugharty, M.D., and R. J. Mason, M.D.
- Health Fair Arrangements Chairman Don W. McLean, M.D., reported that the Health Fair was now scheduled to open September 17, 1965, which leaves an extremely short time for contact with school teachers and school children to arrange tours. The Council authorized an attempt to reschedule the Health Fair.

Grateful Thanks

Sincere appreciation has been voiced by the Michigan State Medical Society to the firm of Merck Sharp & Dohme for its sponsorship of two excellent lecturers at the 1963 MSMS Annual Session.

The two general-session speakers were William H. Wilson, M.D., of Denver, on "Ménière's Disease" and Saul Krugman, M.D., New York City, on "Current Status of Immunization Against Virus Disease."

Both guests essayists brought important messages and the listening doctors were high in their praise.

Honor Four Distinguished Michigan Doctors of Medicine

Four distinguished Michigan doctors of medicine were elected by the 1963 MSMS House of Delegates to receive "Certificates of Commendation" for "Outstanding Contributions to Medicine in Michigan."

Chosen were Forest D. Dodrill, M.D., Bloomfield Hills; Charles J. Jentgen, M.D., Detroit; John M. Sheldon, M.D., Ann Arbor; and Homer H. Stryker, M.D., Kalamazoo.

Special certificates were presented to the four men Tuesday evening, September 24, at the Annual General Meeting of the Society.

The citations read as follows:

Forest D. Dodrill, M.D.—"In recognition of his contributions in early research in heart-lung bypass procedures. A thoracic and cardiovascular surgeon, author, teacher and leader in many medical organizations, he has merited an illustrious reputation."

Charles J. Jentgen, M.D.—"In recognition of his contributions during more than fifty years of medical practice as a surgeon, teacher and medical administrator."

John M. Sheldon, M.D.—"In recognition of his outstanding contributions in medical education, especially in postgraduate medical education. He is a nationally-known authority in allergy and an illustrious leader in the important work of professional medicine."

Homer H. Stryker, M.D.—"In recognition of his contributions as an orthopedic surgeon and inventor of orthopedic equipment. Long active in youth and ahtletic affairs, he is a popular speaker on behalf of free enterprise."

Doctor Dodrill, whose original heart machine developed in cooperation with General Motors Corporation Laboratories is exhibited in the Smithsonian Institute, is a professor of surgery at Wayne State University School of Medicine and a longtime practicing surgeon in Detroit since 1944.

Doctor Jentgen is medical director of St. John Hospital in Detroit and former chief of staff for many years at Providence Hospital, also Detroit. He has practiced general surgery more than 50 years.

Doctor Sheldon, on the University of Michigan Medical School faculty since 1932, is chairman of the Department of Postgraduate Medicine and professor of internal medicine. He also directs the extensive MSMS program of postgraduate clinic days across the state each year.

Doctor Stryker, formerly of Alma and a physician in Kalamazoo since 1938, is nationally known as the designer and inventor of orthopedic instruments and hospital equipment. He has spoken many times in Michigan and the midwest about his views on free enterprise and government regulations.

(Turn to page 1066)

"What type of drug is both a tranquilizer and a muscle relaxant?"

"a tranquilaxant."

TRANCOPAL®

brand of

chlormezanone

is a tranquilaxant

As a tranquilizer, TRANCOPAL (chlormezanone-Winthrop) "is effective in the symptomatic treatment of anxiety."[1] Its tranquilizing properties are similar to those of other mild tranquilizers. Furthermore, it relieves tension of both mind and muscle without interfering with normal activity or alertness.

The muscle relaxant properties of this drug provide an extra dimension of effectiveness... relaxing the spasm which so frequently accompanies psychogenic disorders. Hence, the total therapeutic effect of this true "tranquilaxant" is to produce a relaxed mind in a relaxed body.

Unsurpassed Tolerance: Less than 3 per cent of patients develop side effects with TRANCOPAL (chlormezanone-Winthrop), such as occasional drowsiness, dizziness, flushing, nausea, depression, weakness and drug rash. If severe, medication should be discontinued. In most patients, however, side effects are minor and do not necessitate interruption of treatment. There are no known contraindications.

Available: 200 mg. Caplets® (green colored, scored). 100 mg. Caplets (peach colored, scored), each in bottles of 100.

Dosage: Adults, 1 Caplet (200 mg.) three or four times daily; in some patients 100 mg. three or four times daily suffices. Children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Reference: 1. A.M.A. Council on Drugs: J.A.M.A. 183:469 (Feb. 9) 1963.

1811M

Winthrop

WINTHROP LABORATORIES
New York, N. Y.

What They Said About The Annual Session

(These are only a cross section of the letters received about the Annual Session)

"May I express through you my appreciation to the Michigan State Medical Society and to the Urology Section for all the courtesies you extended me as a guest speaker and scientific exhibitor. Dr. Horning truly was a ubiquitous host, and I'm looking forward to being with him at other meetings in the future. One gains a great deal in preparing for these occasions, and then has the privilege at such meetings of making new friends with doctors interested in the same kind of endeavor. I was most pleased to come to Grand Rapids, and I hope the presentations were helpful to your members."

—William L. Parry, M.D.
Oklahoma City, Oklahoma
Guest Essayist

"Thank you for including me on your program and for the outstanding hospitality that was shown me during my stay."

—Samuel R. Powers, Jr., M.D.
Albany, New York
Guest Essayist

"Thank you for the kind hospitality that the Michigan State Medical Society showed me. I thought the meeting went very well and I enjoyed it a great deal."

—Allan C. Barnes, M.D.
Baltimore, Maryland
Guest Essayist

"This is to express my appreciation to you and all of the other members of the Michigan State Medical Society for the great hospitality which I enjoyed while I was there. I hope that the panel on cerebrovascular diseases was one which stimulated and excited the audience. It certainly is an interesting area at present."

—Irving S. Wright, M.D.
New York, N. Y.
Guest Essayist

"I enjoyed very must the privilege of participating in the recent meeting of the Michigan State Medical Society. Your arrangements were top notch, and I was particularly impressed by the very functional arrangements of the exhibits."

—Edward P. Cawley, M.D.
Charlottesville, Va.
Guest Essayist

"May I extend my thanks to the Society and especially to Dr. John B. Burhans for all the courtesies shown me in Grand Rapids."

—Manuel L. Stillerman, M. D.
Chicago, Ill.
Guest Essayist

"I want to thank you for the thoughtful preparation which resulted in the pleasant arrangements for guests which made my attendance at your meeting a distinct pleasure."

—Juan M. Taveras, M.D.
New York, N. Y.
Guest Essayist

"I enjoyed the visit very much and appreciated the invitation. I am sorry I couldn't stay longer."

—Roger S. Mitchell, M.D.
Denver, Colorado
Guest Essayist

"My wife and I wish to thank you for a most pleasant visit with the Michigan State Medical Society. We thoroughly enjoyed the excellent dinner meeting on Thursday evening. Thank you for the comfortable accommodations."

—R. E. Tschantz, M.D.
President
Ohio State Medical Association

"Just a note to tell you how much I enjoyed the opportunity to participate in the recent meeting of the Michigan State Medical Society. It was indeed a memorable event. Thank you again for the invitation."

—C. H. Millikan, M.D.
Rochester, Minnesota
Guest Essayist

"I would like to thank you for the opportunity which you afforded me to participate in your recent state meeting. I was absolutely overwhelmed with all the courtesy and friendliness shown me. Please extend my sincere thanks to all the people responsible."

—William S. Spicer, Jr., M.D.
Baltimore, Maryland
Guest Essayist

"I enjoyed my trip to Grand Rapids for the 1963 Annual Session. Many thanks to you and your group for your hospitality."

—Saul Krugman
New York, N. Y.
Guest Essayist

"Please extend the sincere thanks of Mrs. Harer and myself for the privilege of attending the 98th annual session of Michigan State Medical Society, and to our gracious host and hostess, Dr. and Mrs. C. Allen Payne, for their part in making our visit so enjoyable! We will never forget the welcome and hospitality extended to us."

—W. Benson Harer, M.D.
President
Pennsylvania Medical Society

Michigan Medical Meetings

Michigan Academy of General Practice, 17th Annual Fall Postgraduate Clinic, November 13-14, Sheraton-Cadillac Hotel, Detroit.

American College of Physicians' First Sectional Meeting, November 21-22-23, Sheraton-Cadillac Hotel, Detroit.

Saint Mary's Hospital "Annual Grand Rounds Program," December 7, Saint Mary's Hospital, Grand Rapids.

Seminar on Automobile Accident Prevention, December 11, Civic Auditorium, Grand Rapids.

Congress of the Professions, February 7-8, Jack Tar Hotel, Lansing.

Third Annual Canadian-American Medical and Dental Ski Association, Feb. 17-19, Harbor Highlands, Harbor Springs, T. J. Trapasso, M.D., Sault Ste. Marie.

Genesee County Medical Society "Alcoholism Day", February 19, Hurley Hospital, Flint.

Michigan Heart Association "Heart Day," February 22, Statler-Hilton, Detroit.

Michigan Clinical Institute, Sheraton-Cadillac, March 11, 12, 13, Detroit.

Michigan State Medical Assistants Educational Seminar, March 11, Statler-Hilton, Detroit.

Important news in cardiac therapy

Two new clinical reports document successful long-term treatment of ischemic heart disease with Persantin®, brand of dipyridamole

See next 3 pages

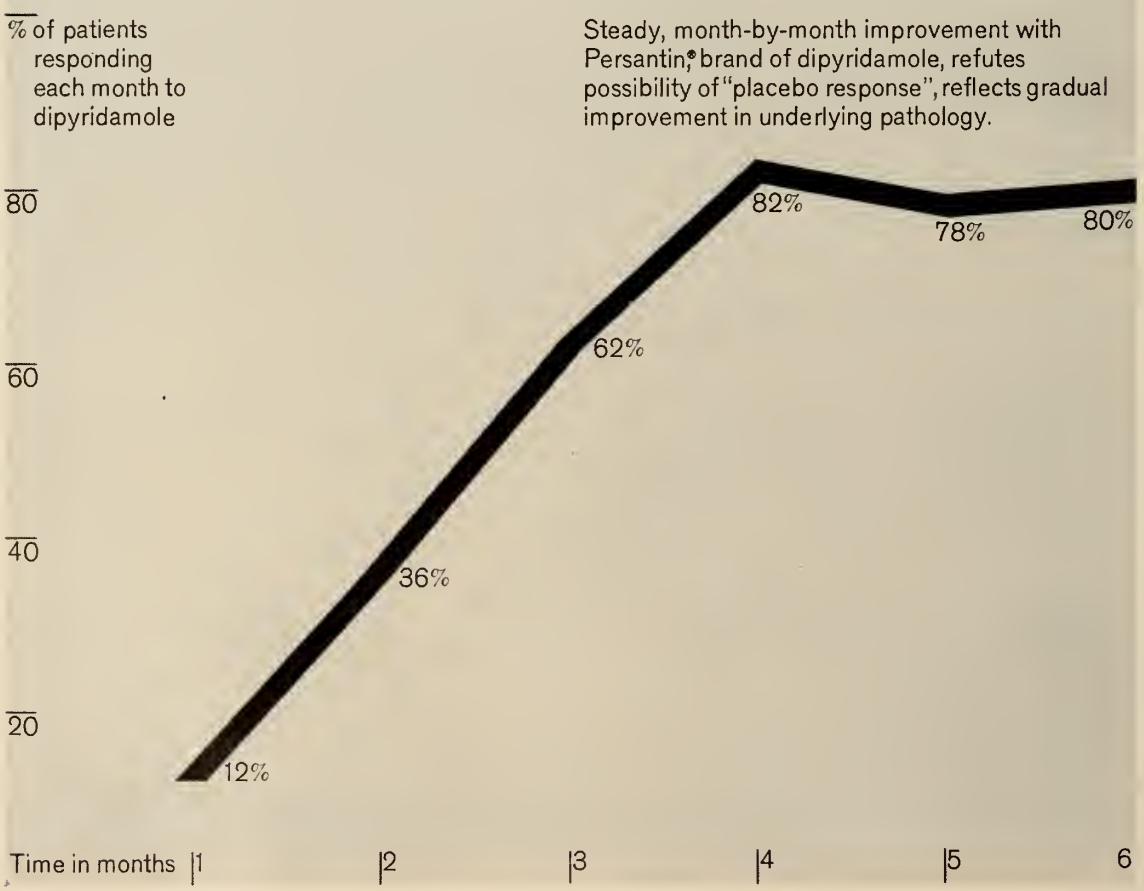
Study 1.
Griep,A.H.: Long-term Therapy of Ischemic Heart Disease With Oral Dipyridamole:
A Report of Fifty Cases. Angiology 14:484, 1963.

Persantin,® brand of dipyridamole, 25 mg. t.i.d. or q.i.d.,was administered continuously for 6 months to 50 patients with well authenticated ischemic heart disease with angina pectoris and ECG abnormalities. Results were evaluated on a monthly basis.

Persantin® brand of dipyridamole

"..long-term oral therapy with dipyridamole was of benefit in 80 per cent of the patients...

"relief [of angina] came slowly and was usually maximal after three to six months of continuous treatment"



Say you saw it in the Journal of the Michigan State Medical Society

Study 2.
Wirecki,M.: Dipyridamole (Persantin®): Evaluation of Long-Term Therapy in Angina Pectoris. Current Therapeutic Research 5:472, 1963.

In 40 ambulatory patients with myocardial ischemia, angina pectoris, and abnormal ECG findings, Persantin,® brand of dipyridamole, 25 mg. t.i.d., was administered continuously for 3 months.

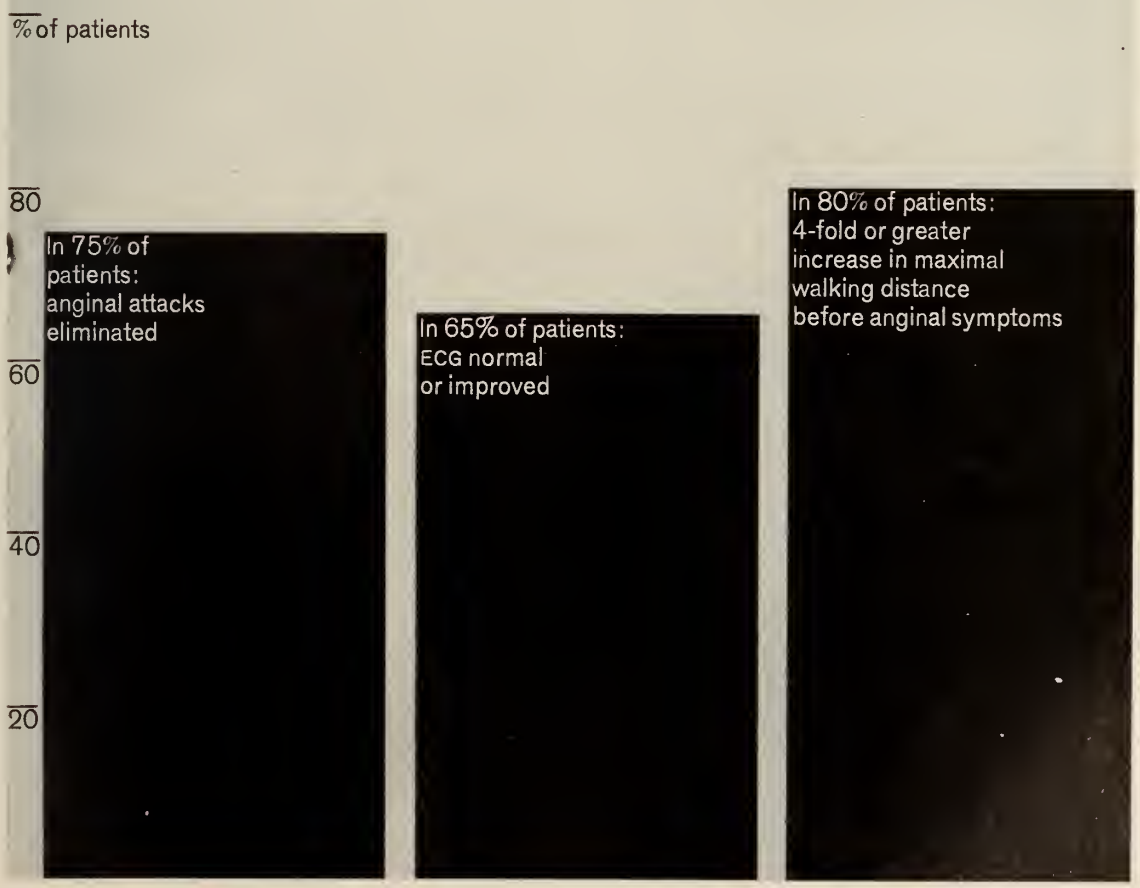
Geigy

After 3 months, 32 of 40 patients showed:

"...reduction or abolition of acute anginal attacks...

"complete or almost complete disappearance of ECG abnormalities...

"marked increase" in walking distance without anginal symptoms



Persantin® brand of dipyridamole

How long-term therapy provides clinical benefits reported on previous pages

1. By increasing energy yield
of the hypoxic myocardial cell, by direct action upon the sarcosomes (heart mitochondria).[1-5]

2. By improving collateral coronary circulation.
Prolonged oral administration of dipyridamole to animals with experimentally induced stenosis of a major coronary artery resulted in superior development of collateral coronary anastomoses and longer survival compared with controls.[6-9]

When given for prolonged periods and in adequate dosage, dipyridamole improves the coronary flow deficit of the ischemic myocardium while supporting cardiac metabolism during the period of repair. Clinically, this is manifested as steady improvement – anginal attacks diminish in frequency and intensity, as do other manifestations of insufficiency (dyspnea, fatigue, and, in many instances, abnormal electrocardiographic findings).

Availability:
Tablets of 25 mg., bottles of 100 and 1000.
Under license from Boehringer Ingelheim G.m.b.H.

Prescribing summary: Persantin,® brand of dipyridamole, is indicated in coronary and myocardial insufficiency, in a dosage of 2 to 6 tablets daily in divided doses before meals for several weeks. Side effects (headache, dizziness, nausea, flushing, weakness, syncope, mild gastrointestinal distress) are minimal and transient. The drug is not recommended in the acute phase of myocardial infarction, and should be used cautiously in hypotension.

References: 1.Kunz,W.;Schmid,W.,and Siess,M.: Arzneimittel-Forsch.12:1098,1962. 2.Siess,M.: Arzneimittel-Forsch.12:683,1962. 3.Laudahn,G.: Experientia 17:415,1961. 4.Lamprecht,W.: 27th Congress of the German Society for Circulation Research,Bad Nauheim,1961. 5.Hockerts,T.,and Bögelmann,G.: Arzneimittel-Forsch.9:47,1959. 6.Vineberg,A.M.,et al.: Canad.M.A.J.87:336,1962. 7.Chari,S.R.,et al.: Presented at the International Congress of Chest Physicians,New Delhi,1963. 8.Neuhaus,G.,et al.: Presented at the Fourth World Congress of Cardiology,Mexico City,1962. 9.Asada, S.,et al.: Japanese Circ.J.26:849,1962.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York, Distributors

PE-2290

Say you saw it in the Journal of the Michigan State Medical Society



STARTING TOMORROW MORNING this capsule can help one of your overweight patients do without her favorite (fattening) foods at meals—and during all the hours in between.

Dexamyl® Spansule®

Trademark — brand of sustained release capsules

Each No. 2 capsule contains 15 mg. of Dexedrine® (brand of dextro amphetamine sulfate) and 1½ gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each No. 1 capsule contains 10 mg. of Dexedrine (brand of dextro amphetamine sulfate) and 1 gr. of amobarbital [Warning, may be habit forming].

The active ingredients of the 'Spansule' capsule are so prepared that a therapeutic dose is released promptly and the remaining medication, released gradually and without interruption, sustains the effect for 10 to 12 hours.

INDICATIONS: (1) For control of appetite in overweight; (2) for mood elevation in depressive states.

USUAL DOSAGE: One 'Dexamyl' *Spansule* capsule taken in the morning.

SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

CAUTIONS: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence; in these rare instances withdrawal of medication is recommended. It is generally recognized that in pregnant patients all medications should be used cautiously, especially in the first trimester.

SUPPLIED: Bottles of 50 capsules.

Smith Kline & French Laboratories SK&F *Prescribing information Jan. 1963*

Say you saw it in the Journal of the Michigan State Medical Society

Welcome, New Members!

Julian Alvarez, M.D.
17380 Monica
Detroit 21, Michigan
Roentgenology-Radiology

Donald C. Austin, M.D.
320 Professional Bldg.
Detroit 1, Michigan

Myron Barlow, M.D.
18050 Mack
Grosse Pointe, Michigan
Dermatology

John M. Blakey, M.D.
William Beaumont Hospital
Royal Oak, Michigan 48072

Melvin Bornstein, M.D.
17600 Northland Park Ct.
Southfield, Michigan

Albert L. Boyd, M.D.
21124 Goddard
Taylor, Michigan
General Practice

Kenneth A. Brown, M.D.
5050 Joy Rd.
Detroit 4, Michigan
Urology

Dennis R. Burke, M.D.
5080 Saline—Ann Arbor Rd.
Ann Arbor, Michigan
General Practice

George J. Chatas, M.D.
St. Joseph Mercy Hospital
Ann Arbor, Michigan
Anesthesiology

Alvin H. Clair, M.D.
24821 Warrington
East Detroit, Michigan
Internal Medicine

Paula G. Davey, M.D.
2620 Whitewood
Ann Arbor, Michigan
Internal Medicine

Nestor D. Deocampo, M.D.
11702 E. 11 Mile Rd.
Warren, Michigan

Robert A. Dye, M.D.
124 Fulton Street, E.
Grand Rapids 2, Michigan
Ophthalmology

Nathan S. Firestone, M.D.
10151 Michigan Avenue
Dearborn, Michigan
Pediatrics

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604 Indianola Drive
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Hamilton, Michigan

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Owosso, Michigan

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9559 Greenfield
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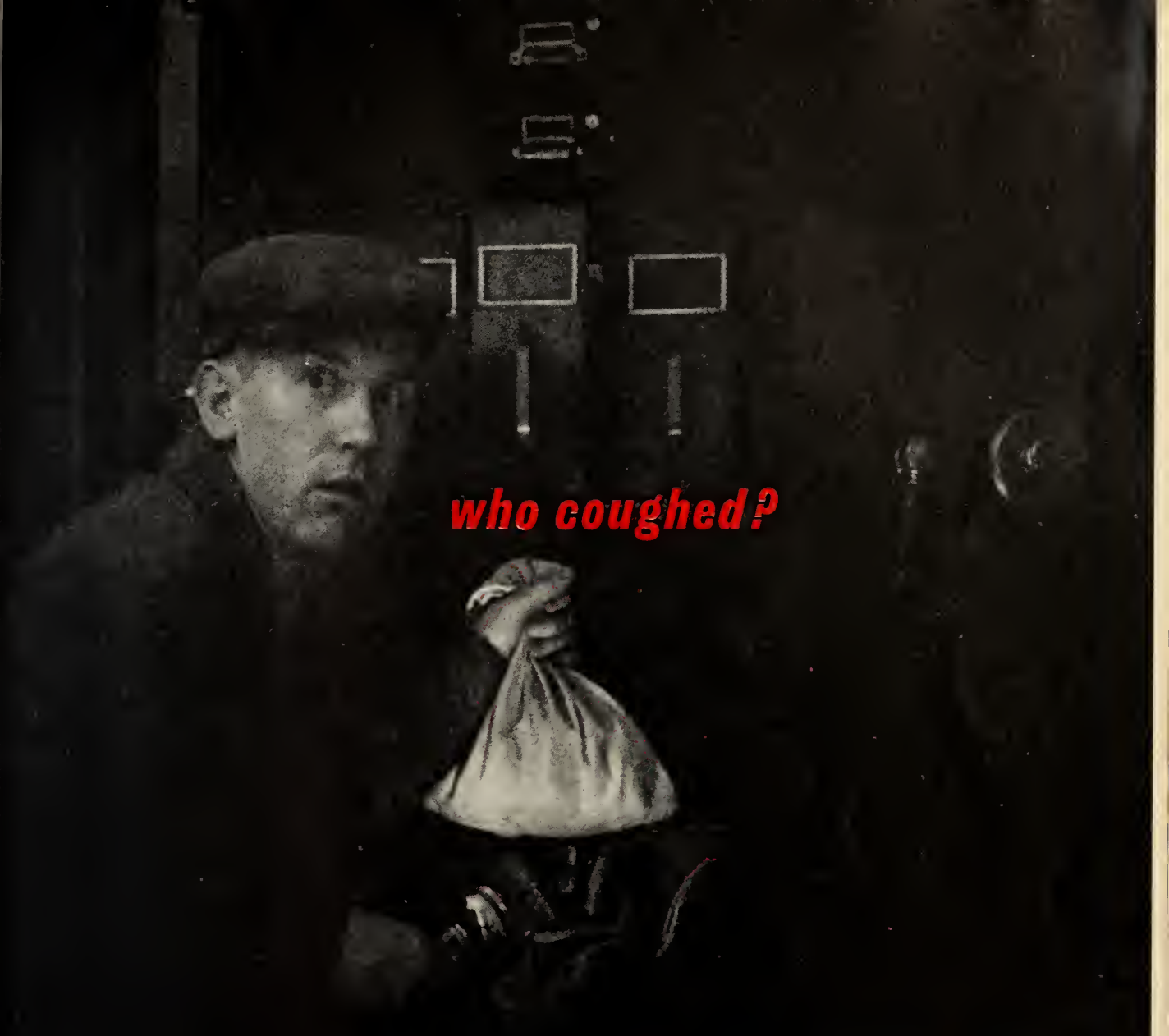
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DOSAGE: Average adult dose—1 teaspoonful after meals and at bedtime with food. Children 6 to 12 years, ½ teaspoonful; 3 to 6 years, ¼ teaspoonful; 1 to 3 years, 10 drops; 6 months to 1 year, 5 drops; after meals and at bedtime. On oral Rx where state laws permit. U. S. Pat. 2,630,400.

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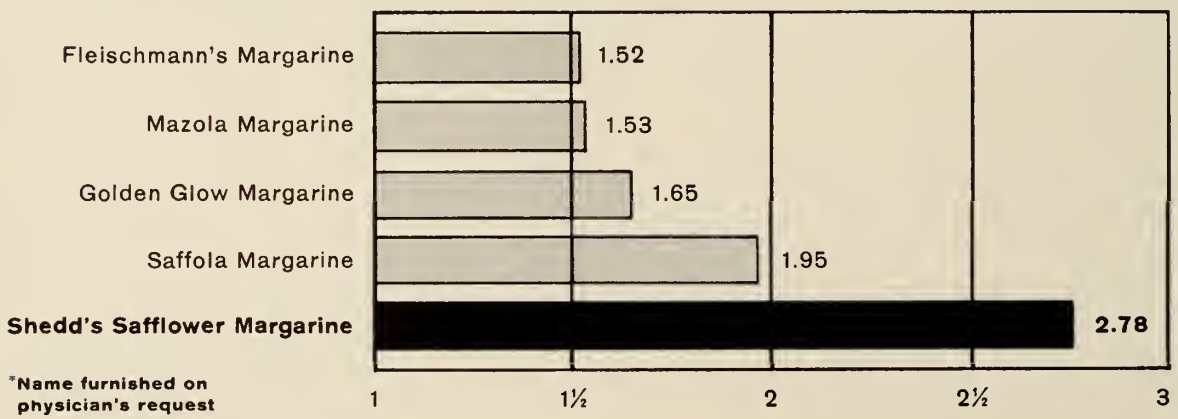


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320,000 in Kent County Get Oral Polio Vaccine

The Kent County Medical Society played a key role in the "KO Polio Day" efforts in Kent County September 21 when 86 per cent of the county population received polio vaccine.

Kent County doctors, with the help of pharmacists, nurses and other paramedical groups, manned many distribution centers throughout the county. At the end of the day, more than 320,000 people had been served. During the following day, follow-up clinics were held for the 50,000 who did not previously take the vaccine.

Officials of the U. S. Public Health Service, who flew in federally-stockpiled oral polio vaccine, lauded the project as "tremendously successful."

The Medical Society and other cooperating groups developed the project after five cases of paralytic polio were reported in a six-week period in Grand Rapids.



Genesee County Society To Sponsor Alcoholism Day

The Committee on Alcoholism of the Genesee County Medical Society has designated February 19, 1964 as "Alcoholism Day."

The program for the day will include:

Howard Rome, M.D. "The Psychiatric Approach to Alcoholism." Minneapolis, Minn.

Gordon Bell, M.D. "Treating the Alcoholic" Toronto, Canada

B. H. Sullivan, M.D. "The Organic Toxicity of Alcoholism" Cleveland, Ohio

Richard C. Bates, M.D. "The Diagnosis of Alcoholism in the Doctor's Office" Lansing, Michigan

J. A. Baillie, M.D. "Care of Alcoholics in Industry" Toronto, Canada

Physicians interested in acquiring more knowledge of alcoholism will want to attend this program.

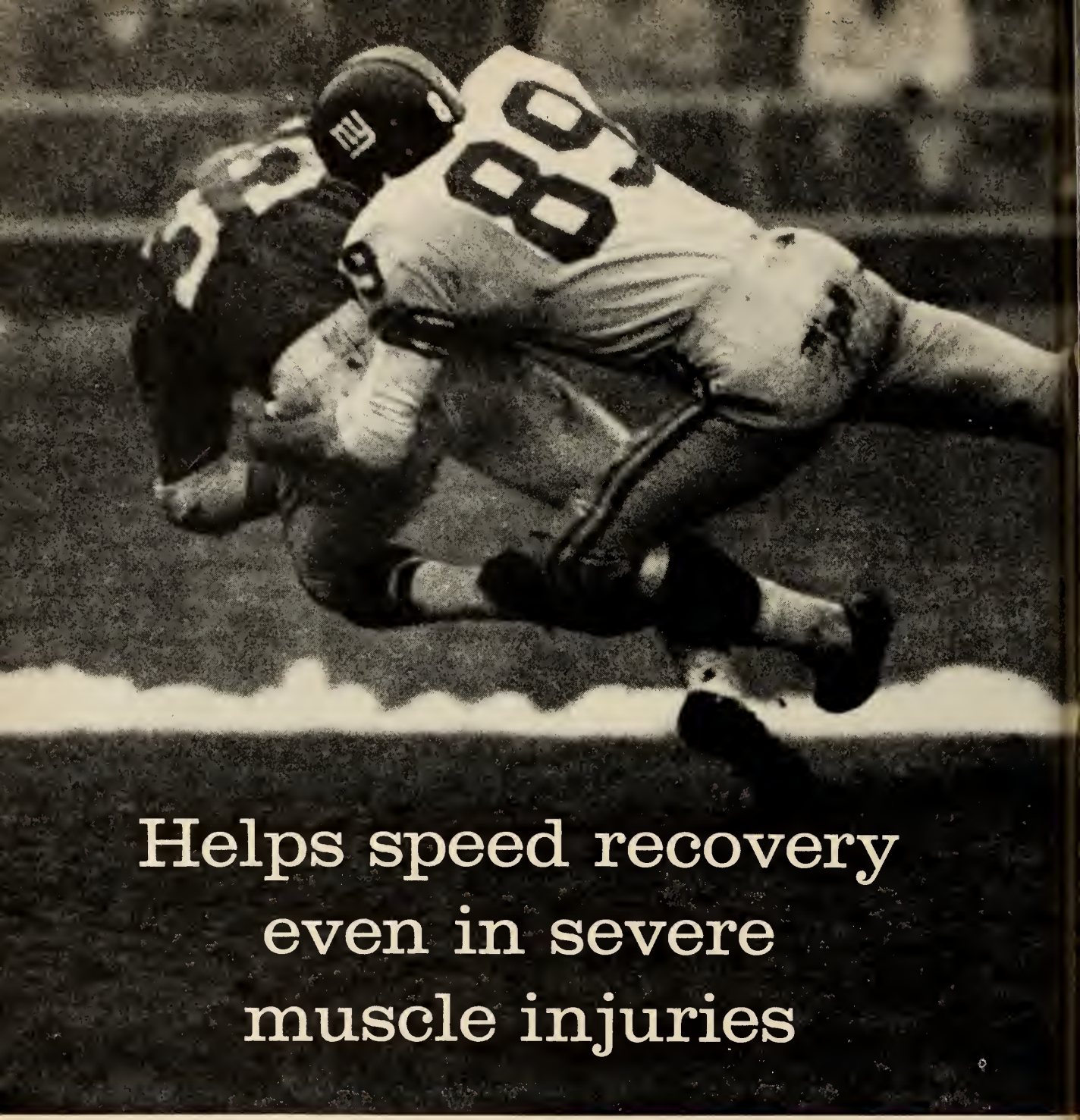
Genesee doctors are among the leaders in the State in their interest in alcoholism and alcoholics, so it is typical that they should be the first county society to devote a "day" to this subject.

Eaton M.D.'s Offer Course

The Eaton County Medical Society is cooperating in the sponsorship this autumn of a series of expectant parents classes, held in Charlotte. Offered without an enrollment fee, the series will include seven classes and a special tour of the maternity section of the hospital.

Calhoun Helps College Student

The Calhoun County Medical Society has presented a $50 check to Miss Billie J. Warson, 122 West North Street, Albion, to help her attend the Science Orientation Institute at DePauw University in June. Miss Warson is an outstanding student at DePauw.



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Cost of Hospital Care Has Doubled in Ten Years

By Richard M. Campau,
MSMS Research Director

The American Hospital Association has just released a report regarding the economics of non-federal short-term general hospital care. Highlights are as follows: The 7,028 hospitals registered with the American Hospital Association spent $10,129,216,000 last year to provide health care for 26,531,365 patients. The average patient's daily expense rose from $18.25 to $36.83 in the last ten years. The total expense of an average stay in the hospital—slightly more than a week—rose from $148 to $279.



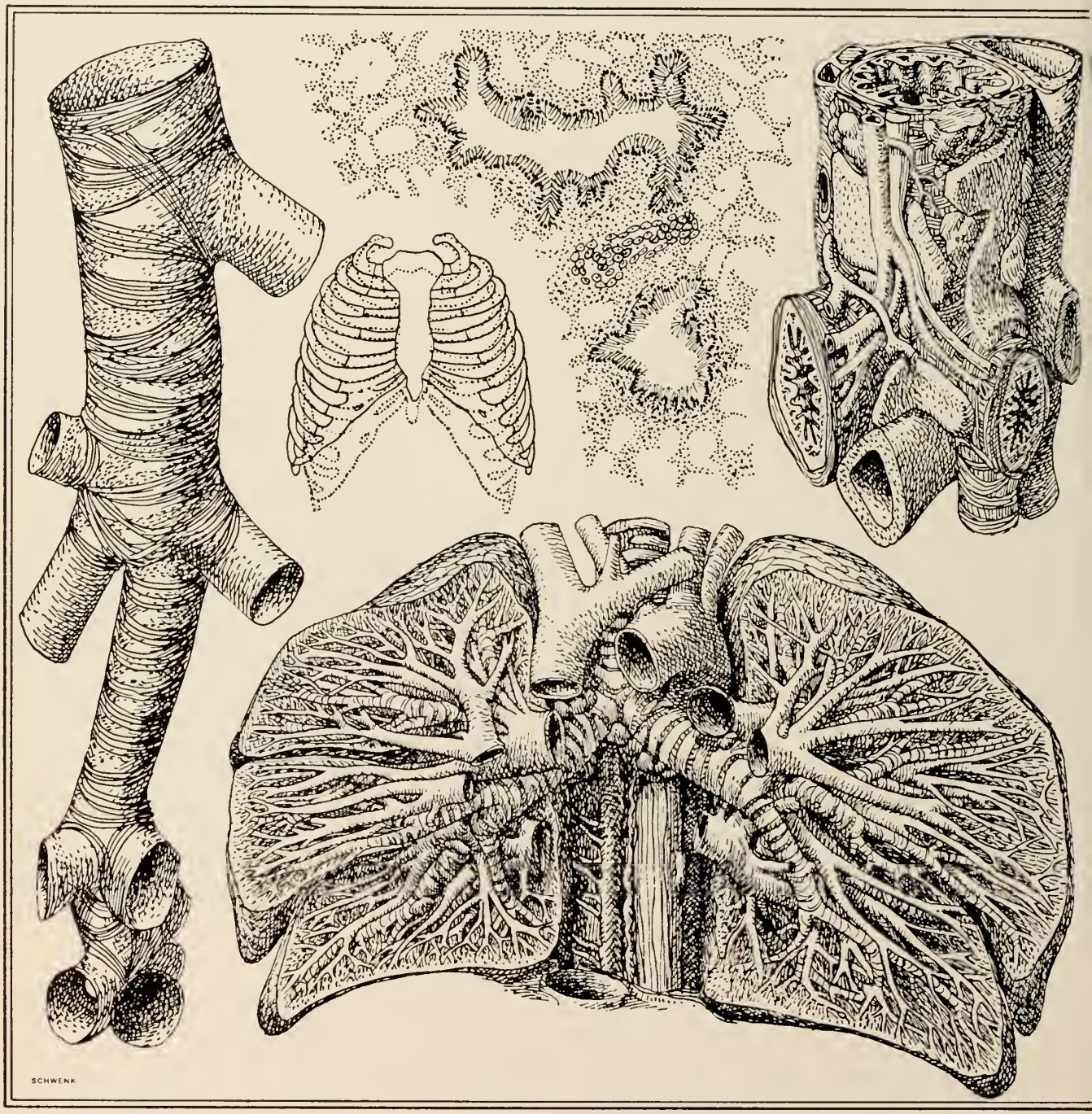
LENGTH OF STAY—The average length of stay for non-federal short-term general and other special hospitals remained the same in 1962 as it was in 1961—7.6 days.

FACILITIES AND SERVICES—582 hospitals (10.8 per cent) reported having psychiatric inpatient care units; 349 hospitals (6.5 per cent) reported having rehabilitation units; and 917 hospitals (17 per cent) reported having cobalt and radium therapy facilities.

OUTPATIENT VISITS—Of the 7,028 registered hospitals, 5,291 hospitals (75.3 per cent) reported a total of 99,382,469 out-patient visits for the 12-month reporting period. As expected, the larger the hospital, the more likely it was to provide outpatient services. The 121 non-federal short-term general and other special hospitals having more than 500 beds reported more than 17 million visits, an annual average of 140,000 outpatient visits per hospital.

RISING LABOR COSTS—The report said that steadily rising labor costs were the major cause of increased expenses. Some 1,762,-957 persons were employed in short-term hospitals last year, 66,825 more than during the previous year. For each 100 patients in a short-term general hospital, 237 employes were required. Since 1946, labor costs not including fringe benefits, increased 333 per cent while non-labor costs rose slightly more than 200 per cent. Payroll expenses account for nearly 67 per cent of operating costs of hospitals.

The Michigan Hospital Association reports that between 1953 and 1962, patient revenue per day of care at Michigan's voluntary short-term general and special hospitals increased from $22.55 to $34.29 (52.0 per cent). In the same period, payroll costs as a percent of total operating cost increased from 62.0 per cent to 62.7 per cent. The number of employees per 100 patients rose from 205 to 250.



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Cholesterol Metabolism and Pharmacologic Attempts at Regulation of Its Plasma Level

A Brief Review

Allen R. Hennes, M.D.
Detroit, Michigan



THOUGH the relationship of cholesterol to atherosclerosis is far from clear, and no definite data exist indicating that lowering of plasma cholesterol *per se* will inhibit, prevent, or ameliorate atherosclerosis, there is no doubt that cholesterol exists in atherosclerotic plaques and may play some role in their genesis. There is also no doubt that its metabolism has been closely and carefully studied, and many attempts have been made to regulate its level in plasma. It is the purpose of this review briefly to summarize our current knowledge of cholesterol metabolism and attempts which appear to be of interest in regulating its level in plasma.

Cholesterol is an important physiological constituent of cells. It appears to exist bound to lipoproteins as part of the external membranes of cells and also of intracellular membranes in structures such as mitochondria. It may thus play an important part in membrane transport. It serves as a precursor for steroid hormones in the adrenals, ovaries, and testes. Further, it may be a necessary growth factor for cells. This function has been demonstrated in cell cultures of mammalian tissue.[1]

The great physiological importance of cholesterol is reflected in the great capacity of mammalian tissue to synthesize it. The synthesis of cholesterol by liver has been studied extensively and the enzymatic pathways at least partially clarified. It seems likely that the liver is the major source of plasma-free cholesterol.[2] It is less well known that cholesterol is synthesized in other tissues. Mammalian intestinal wall,[3] connective tissue,[4] arterial wall,[5] leukocytes and platelets,[6] skin,[7] and peripheral nerve[8] have been clearly shown to be capable of active cholesterol synthesis. The most generally accepted pathway of cholesterol synthesis proceeds by way of the apparently obligatory intermediates mevalonic acid[9] and squalene[10] to cholesterol (Fig. 1). The major site of control of cholesterol synthesis in the liver has been shown by Siperstein and Guest to lie between hydroxymethyl glutaric acid and mevalonic acid.[11] It has been suggested by Gould that the major factor controlling cholesterol synthesis at this site is the concentration of cholesterol in liver[12] which in turn may be controlled by conversion of cholesterol to bile acids.[13]

From the Department of Medicine, Wayne State University College of Medicine, Detroit, Michigan.

This work is supported in part by a grant from the Michigan Heart Association.

Absorption of dietary cholesterol is aided by simultaneous presence of fatty acids and partly hydrolyzed triglycerides. It is also increased by the presence of bile acids, the major products of cholesterol degradation. During its passage through the intestinal wall, cholesterol is esterified and is transferred into the lymph as esterified cholesterol[14] largely attached to chylomicrons. In the liver, the newly formed ester cholesterol is apparently hydrolyzed, yielding free cholesterol and fatty acids.[15] The newly absorbed cholesterol mixes indistinguishably with cholesterol of endogenous origin.

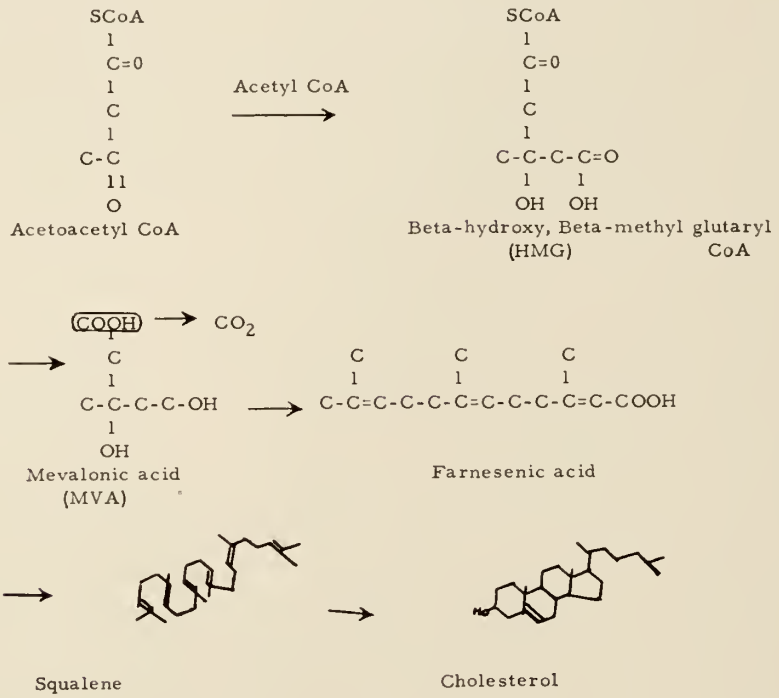


Fig. 1.

Cholesterol is transported in the plasma bound to lipoproteins. Approximately one-fifth is normally bound to alpha-lipoproteins; four-fifths to beta-lipoproteins.[16] Alpha-lipoprotein contains a much higher ratio of protein and phospholipid to cholesterol than does the beta-lipoprotein. The higher percentage of protein and phospholipid renders the alpha-lipoprotein more soluble in the aqueous medium of the blood. It is also likely that the linkage of lipids to alpha-lipoprotein-protein is much stronger than to beta-lipoprotein-protein.

Cholesterol has two major excretory pathways—degradation to bile acids, and excretion as fecal sterols. The degradation to bile acids is probably the major pathway under most circumstances, accounting for approximately 90 per cent of cholesterol excreted.[17] This may vary, however—at least in that most-studied creature, the laboratory rat—depending on the amount of cholesterol fed and absorbed. Excretion as bile acids increases as the amount of dietary cholesterol absorbed increases.[18]

As perhaps one can surmise from the above brief summary of normal cholesterol metabolism, attempts have been made to decrease the level of plasma cholesterol by altering one or several of the physiological processes involved in normal cholesterol metabolism.

First, one might consider altering plasma cholesterol by limiting cholesterol in the diet. The effect of cholesterol feeding in man on plasma cholesterol levels is not completely clear. Mayer et al have shown in short-term experiments that large amounts of dietary cholesterol do not appear to increase plasma cholesterol levels.[19] However, Conner et al[20] have shown in long-term studies that increased dietary cholesterol, particularly when fed as egg yolk, may elevate the cholesterol level in man. Beta-sitosterol, a vegetable sterol which apparently competes with cholesterol for absorption in the gut, has also been used to limit absorption of cholesterol.[21] It also appears to inhibit deposition of cholesterol in arterial walls in choles-

terol-fed mice.[22] However, other studies have shown that beta-sitosterol may be deposited in the aorta of man after oral administration.[23]

Effects of dietary factors, other than cholesterol, on plasma cholesterol levels have been extensively studied. The effect of dietary fat on the level of plasma cholesterol has been particularly closely scrutinized. Groen[24] and Kinsell[25] were the first to demonstrate that diets in which unsaturated fat was substituted for saturated fat produced a definite reduction in plasma cholesterol levels in man. Ahrens and his co-workers have also clearly shown that diets high in unsaturated fat lower cholesterol while diets of the same caloric content, but high in saturated fats, raise serum cholesterol.[26] An interesting study of the effect of diet on serum cholesterol in various types of vegetarians has shown a definite decrease of serum cholesterol in subjects with a high ratio of poly-unsaturated to saturated fat in their diet.[27] Though the effect of unsaturated fats on level of plasma cholesterol in man is clear, the exact mechanism is unknown. A suggested mechanism of action has been an increase in excretion of cholesterol as bile acid.[28] Although Ferguson and Coniglio have found no evidence for this postulate in the rat,[29] Hauge has shown that an increase in formation and excretion of bile acids occurs in human subjects following administration of poly-unsaturated fatty acids.[30] Feeding diets high in linoleate increases the amount of linoleate in cholesterol esters.[27,31] This ester may be more soluble in plasma, and thus perhaps less likely to leave the plasma and enter atheromatous plaques.

Effects of dietary carbohydrates on cholesterol have been studied in the experimental animal, with somewhat confusing results. Certain carbohydrates such as dextrose, maltose, fructose, and starch may increase levels of serum cholesterol in cholesterol-fed animals.[32] However, lactose has been shown to inhibit formation of cholesterol from both acetate and mevalonate in vitro.[33] The in vivo effects may well be due to changes in the bacterial flora of the gut which in turn influence bile acid formation and hence degradation of cholesterol.[13]

Interesting attempts have been made to lower cholesterol by inhibiting its synthesis in man and in experimental animals. Inhibitors have been in general of two types—those which inhibit cholesterol formation at a stage prior to formation of mevalonate, and those which inhibit cholesterol formation at a later stage between mevalonate and cholesterol. Inhibitors of the early stage, prior to mevalonate formation, are phenylbutyramide and benzmalacene. Both agents inhibit cholesterol formation in vitro[34,35] and in experimental animals.[34,35] However, neither has proved too useful in limited clinical trials in humans.[36,37,38] MER 29 was used extensively to lower cholesterol levels prior to discovery of its toxic effects. It acts



Desmosterol Cholesterol

Fig. 2.

at a later stage in cholesterol formation, inhibiting the formation of cholesterol from its immediate precursor desmosterol.[39] As can be seen from Figure 2, desmosterol differs very little structurally from cholesterol and has in fact been shown to be handled similarly to cholesterol in that it is incorporated with great facility into atheromatous plaques,[40] and may also serve as a precursor for steroid hormones and bile acids.[41]

Since it is well known that thyrotoxicosis is associated with low levels of plasma cholesterol and in the experimental animal with high rates of cholesterol degradation,[42] dessicated thyroid, and more recently various thyroid analogues, have been used clinically to lower serum cholesterol. D-thyroxin, D-tri-iodothyronine, tri-iodothyroacetic acid, and other thyroid analogues appear to retain some cholesterol lowering potency, while being largely, but not completely, lacking in ability to increase oxygen consumption and myocardial metabolism.[43,44] Thyroid hormones appear experimentally to increase synthesis of cholesterol from acetate,[7] but increase degradation to bile acids to an even greater extent, resulting in a net decrease in plasma cholesterol.[42]

Hellman et al have found that androsterone, a metabolite of androgens, is decreased in hypothyroidism, and that androsterone will decrease cholesterol levels when administered to hypothyroid or normal subjects.[45] They have postulated that some of the effect of thyroid hormone in lowering cholesterol may be indirect and due to increased formation of androsterone. Experimental and clinical attempts to lower cholesterol levels by using androsterone are now in progress.

The use of estrogens to lower cholesterol, and to prevent recurrence of coronary thromboses has been under extensive study for a number of years. Estro-

gens have two known effects on cholesterol metabolism. They shift cholesterol from beta to alpha-lipoprotein.[46] They also appear to inhibit formation of cholesterol from mevalonate in vitro.[47] It is interesting that different estrogenic substances appear to have different effects in preventing recurrences of myocardial infarction, even though their cholesterol lowering effect is similar. Oliver and Boyd have shown that ethinyl estradiol is ineffective in preventing recurrences of myocardial infarction,[48] while Katz, Stamler, et al have shown that premarin definitely decreases the incidence of recurrent myocardial infarction.[49]

Nicotinic acid in large doses has been shown to lower serum cholesterol in some patients.[50] However, side effects—such as flushing—may make its use difficult, particularly in the early stages of treatment. Its mechanism of action is not clear. It appears to increase cholesterol degradation to bile acids;[51] secondarily, there appears to be an increase in formation of cholesterol from acetate.[52]

Other interesting experimental work in cholesterol metabolism which may be soon (and in some cases already is) reaching a stage of clinical interest should also be mentioned. As was previously noted, cholesterol is degraded largely to bile acids. Beher and co-workers have fed various types of closely related bile acids to mice and have found that they have different effects on cholesterol synthesis and on liver cholesterol level. Cholic acid was found to increase hepatic cholesterol levels while decreasing the rate of synthesis, indicating interference with mobilization. Deoxycholic acid decreased hepatic cholesterol level while also decreasing synthesis. On the other hand, hyodeoxycholic acid increased cholesterol synthesis while decreasing hepatic cholesterol level, probably indicating an effect on increasing mobilization of cholesterol.[53] In another study, cholic acid was found to increase cholesterol level in plasma, liver, and carcass, while hyodeoxycholic acid reversed the effect of cholic acid and prevented cholesterol accumulation.[54] The type of bile acid made appears to depend to some extent on the predominant gut flora.[55,56] It is of interest in this regard that germ-free animals have been shown to have a considerably slower rate of bile acid degradation than do normal animals,[13] and also maintain higher levels of serum cholesterol.[57]

Trace metals have considerable effect in vitro in regulating cholesterol formation. Chromous, chromic, manganous, and ferric ions stimulate cholesterol formation, while vanadous, ferrous, and cobaltous ions decrease cholesterol formation.[58,59,60] Recent clinical tests with vanadium have shown it to be non-toxic, but apparently without effect on lowering cholesterol.[61]

This brief review is but a small sample of the work which has been done relating to cholesterol metabolism. It is important to remember that despite all this work, no direct causal relationship has been demonstrated between cholesterol and human atherosclerosis. Elevated serum cholesterol may be only an indicator of some more subtle underlying metabolic abnormality. For example, lowering serum cholesterol could increase, decrease, or have no effect on atheroma formation, depending perhaps on the mechanism of lowering cholesterol and simultaneous effects on other lipids which may be involved. It has recently been suggested that elevated serum triglycerides correlate more closely than does elevated cholesterol, at least in relatively young people, with myocardial infarction.[62] Some agents which lower cholesterol could have no effect, or might even increase the triglyceride level. It is, therefore, important when administering an agent which lowers cholesterol to not only consider how it acts in lowering cholesterol, but also to consider what effect it may have on other lipid moities, some of which may be even more important than cholesterol in atheroma formation.

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The Internist and Postoperative Care Following Cardiovascular Surgery

Seymour Gordon, M.D.
Gerald C. Timmis, M.D.
Robert H. Baron, M.D.
Detroit, Michigan

THE TEAM approach is widely utilized in the field of cardiovascular surgery so that the internist performs a significant function not only in the preoperative diagnostic aspects of patient care, but also is an active participant during the surgical procedure and in the postoperative period. The survival of patients undergoing cardiac surgical procedures depends not only upon the accuracy of the preoperative diagnosis and the skill of the surgeon, but to an equally large degree upon the intensive postoperative care provided by both the medical and surgical members of the team. This paper deals with some of the medical complications seen during the period of hospitalization following surgery.

The postoperative period may be divided into the early period which occurs in the operating room and in the postanesthetic recovery room and the late period concerned with the care of the patient thereafter.

Early Postoperative Period

Arrhythmias.—It has been reported that one-third to one-half of patients have transient arrhythmias following surgery.[1-3] Our own experience parallels these reports with an incidence of 37.9 per cent. The most common arrhythmia in our adult patients is atrial fibrillation and the most common in children is a form of relatively slow nodal rhythm termed non-paroxysmal nodal tachycardia by Rabbino, Dreifus and Likoff.[1] The occurrence of arrhythmias cannot be related to the etiology of heart disease (acquired vs. congenital), the type of cardiac defect, the length of the operation, the use of a patch vs. suture closure techniques, the occurrence of acidosis or the location of the venous return catheters.[3] The more serious arrhythmias are, however, more frequently associated with hypothermia.[1,4]

The occurrence of occasional premature systoles, controlled atrial fibrillation or first degree A-V block represent effective mechanisms and the cardiac output can be maintained at an adequate level. Our experience with the non-paroxysmal nodal tachycardia appears to differ significantly from that previously reported by others. Rabbino, et al,[1] consider this to be a transient and benign arrhythmia requiring no therapy if it is not associated with complete A-V dissociation. It has been our experience, however, that the rate of the A-V nodal pacemaker, usually 80-90 per minute, appears to be inadequate to maintain a normal cardiac output, so that hypotension, oliguria and loss of consciousness occur. We have found the use of intravenous isoproterenol effective under such circumstances. This agent is infused at that empirically determined rate necessary to increase the rhythmicity of the sinus node enabling it to resume pacemaking. This isoproterenol-dependent rhythm is maintained at a rate of 100-120 beats per minute. Concomitant with the change in pacemaker and increase in rate, the patient regains consciousness, the blood pressure rises to normotensive levels and the oliguria disappears. The effect of increased cardiac output may be due to the inotropic or tachycrotic actions of isoproterenol or may result from restoration of the normal sequence of atrial contraction preceding the ventricular contraction.[5] The infusion is periodically slowed to see if sinus rhythm persists and usually can be discontinued after 24 to 48 hours. In a minority of patients with non-paroxysmal nodal tachycardia, no signs of inadequate cardiac output appear and no special treatment is required. These patients spontaneously revert to sinus rhythm. Side effects from the use of isoproterenol in large quantities are infrequent although

Doctor Gordon is Assistant Professor of Pediatrics, Wayne State University College of Medicine. Director of Cardiovascular Laboratory, Children's Hospital of Michigan. Clinical Assistant Physician, Harper Hospital, Detroit, Michigan.

Doctor Timmis is Assistant Professor of Pediatrics, Wayne State University College of Medicine. Co-Director of Cardiovascular Laboratory, Children's Hospital of Michigan. Clinical Assistant Physician, Harper Hospital, Detroit, Michigan.

Doctor Baron is a Fellow in Cardiology, Children's Hospital of Michigan and Department of Pediatrics, Wayne State University College of Medicine, Detroit, Michigan.

it should be remembered that this sympathomimetic amine may cause central nervous system stimulation manifested by restlessness, irritability and convulsions.

It is our practice to digitalize all patients prior to open-heart surgery, regardless of the state of cardiac compensation, since it has been repeatedly observed that digitalized patients have a less complicated postoperative course.[6] The use of Digoxin in patients without cardiac decompensation has been shown to have no undesirable effect.[7] The cardiac output may be slightly decreased transiently, but is rapidly restored to its basal state. The administration of digitalis to patients with cardiac disease who are not in congestive heart failure may improve myocardial function as measured by increased myocardial contractility,[8] a more rapid rise of the ventricular systolic pressure pulse[9] and a decrease in total body oxygen debt after exercise.[10] We routinely use Digoxin because of its rapid onset of activity and its relatively short duration of action. Digoxin which has been fixed in the myocardium prior to the institution of cardiopulmonary bypass remains in the myocardium despite the gross dilution of the patient's intravascular fluids with donor blood and pump-priming solutions.[11-12] Because of possible increased sensitivity of the myocardium to digitalis in the first 24 hours after cardiopulmonary bypass,[13] additional digitalis is used cautiously in the immediate postoperative period.

There is danger in using intravenous calcium in the immediate postoperative period for its inotropic or chronotropic action since rapidly administered intravenous calcium even in small doses to a "fully" digitalized patient may produce toxic arrhythmias. Pronestyl and quinidine are utilized for active, ectopic arrhythmias such as frequent premature systoles or ventricular tachycardia regardless of the underlying cause. Intravenous potassium may be utilized in the same manner although it is usually used only when the underlying cause is excessive digitalis. All three of these agents, however, must be used cautiously or not at all in the presence of partial or complete heart block since these agents may induce further depression of the A-V node or ventricles. Highly concentrated intravenous hyaluronidase for the treatment of complete heart block associated with acute myocardial infarction has been reported,[14] although we know of no similar use in complete heart block secondary to cardiac surgical procedures. If such heart block is due to local inflammation and edema resulting from surgical trauma, this agent may be helpful in producing a more rapid return to normal A-V conduction.

Hypotension.—The most common causes of hypotension in the early postoperative period are the presence of an ineffective cardiac rhythm as discussed above, hypovolemia resulting from inadequate blood replacement during surgery and continued intrathoracic bleeding. Hypovolemia may develop during bypass from inaccurate estimation of blood lost from the operative site or from the sequestration of fluids outside the patient's vascular compartment. The exchange of large quantities of homologous blood during bypass has been reported to cause sequestration of both red cells and plasma in areas not measurably in communication with circulating blood volume.[15,16] This leads to errors in blood balance measurements which may be of such magnitude as to cause significant systemic hypovolemia. Failure to compensate for this deficiency by infusion of additional blood may result in severe postperfusion hypotension. Because reliability on inaccurate blood volume measurements is dangerous, clinical signs of hypovolemia are utilized in assessing the patient's blood volume. The patient is transfused until arterial blood pressure is in the normal range, while the venous pressure is continuously monitored to make certain that the patient is not overloaded. A rise in venous pressure indicates that the myocardium is unable to handle the intravascular volume already present and continuing transfusion would only further reduce myocardial reserve. At this point, transfusion is stopped and inotropic agents used if the venous pressure remains high or the arterial pressure continues low.

Following transfer to the postanesthetic recovery unit, continued intrathoracic bleeding into the pleural and mediastinal spaces may produce hypovolemia and hypotension. Clinically the presence of hypovolemia as the cause of the hypotension is suspected by peripheral vasoconstriction with cold, cyanotic extremities, oliguria and a low or normal venous pressure. Under such clinical circumstances the patient is transfused with whole blood until the arterial blood pressure is normal and the clinical signs of hypovolemia are no longer apparent. The venous pressure is again continuously monitored during the course of such transfusions to make certain that the cardiac reserve is not overwhelmed.

Inadequate surgical hemostasis is a rare cause for excessive postoperative blood loss. It is not uncommon, however, in the immediate postoperative period for the patient to continue to ooze a considerable amount of blood although no specific bleeding points

can be demonstrated. Prior to the institution of cardiopulmonary bypass the patient receives 3 mg/kg. of heparin which is neutralized with an equal amount of either polybrene or protamine sulphate at the termination of the pump procedure. Neither of these agents is ideal. Polybrene in excessively large amounts has been demonstrated to cause renal lesions[17] and there is some question as to the reliability of the potency standardization of polybrene. Excessive protamine sulphate is known to activate the fibrinolytic system and may produce bleeding. However, in proper amounts these agents are effective in neutralizing the heparin activity and are non-toxic. Despite the fact that no deficiency of the clotting factors can be measured, bleeding may continue. Replacement of losses with fresh blood has usually proven beneficial. On several occasions we have had the experience of producing almost immediate cessation of bleeding utilizing fibrinogen even though chemical determinations of the fibrinogen level have been normal. We have no explanation for this, although the quantitatively normal fibrinogen may be qualitatively changed. To our knowledge no extensive studies have been done on the possible effects of cold agglutinins which may be activated during the course of hypothermia associated with cardiopulmonary bypass and may cause small vessel damage with bleeding.

In rare instances, the myocardium seems to be the primary factor in the production of hypotension and the use of inotropic agents is indicated. Small increments of short-acting digitalis are utilized unless arrhythmias commonly associated with over-digitalization are present. If it is suspected that additional digitalis may result in toxicity, small increments of intravenous calcium may be given to judge the state of digitalization. If the irregular rhythm is due to digitalis, the added calcium will usually cause a very transient aggravation. If the arrhythmia is not due to digitalis, and if the hypotension is due to inadequate myocardial function the calcium will improve or alleviate the hypotension without increasing the arrhythmia and may even abolish it. After the effect of calcium is dissipated further digitalis may be given if indicated.

Sympathomimetic agents are utilized to maintain blood pressure when hypotension persists and the factors of hypovolemia and inadequate digitalization are ruled out. It is necessary to realize that there is a significant difference in activity among the various sympathomimetic agents. Epinephrine and norepinephrine produce an increase in cardiac contractility of a short duration. In addition, norepinephrine will produce an increase in peripheral vascular resistance, whereas epinephrine will produce an actual decrease in peripheral vascular resistance. Metaraminol and mephenteramine will produce increased cardiac contractility of a longer duration. Both agents also have an effect in increasing the peripheral vascular resistance. Methoxyamine has essentially no effect on myocardial contractility and should not be used for "cardiogenic" shock since the increase in blood pressure resulting from increased peripheral resistance increases the work of the heart.

Other means of assisting the myocardium transiently are available, although we know of no large experience with these means. Following the trauma of cardiopulmonary bypass induced by ventriculotomy and ischemia the function of the left ventricle may be temporarily depressed. If means of assisting the left ventricular function for a short period of time could be utilized, it might be possible for the left ventricle to recover sufficiently so that it could carry the systemic circulation unassisted. The technique of counterpulsion would seem to be appropriate for use under these circumstances.[18] This technique allows a decrease in left ventricular work and maintains adequate systemic and coronary artery perfusion. Following such assistance for a period of hours it may be possible that the left ventricle itself will be able to function in an adequate fashion. A similar situation occurs in patients with severe pulmonary hypertension, when in the postoperative period the right ventricle seems unable to maintain adequate flow against the resistance of the pulmonary bed. Venoarterial shunting, such as has been used in emergency treatment of large pulmonary emboli or acute myocardial infarction, may allow significant recovery of the right ventricle and possibly some regression of the pulmonary arterial vasoconstrictive elements, so that the right ventricle may resume an adequate function. We have utilized the venoarterial shunting in two patients with only short term success, both dying within hours after the venoarterial shunting was discontinued. We have no personal experience with the counterpulsion technique, although in theory it holds promise of some possible success.

Renal Function.—The frequent disturbance of renal function noted after cardiopulmonary bypass procedures has led some surgeons to use dextrose or macromolecular solutions during the pump procedure

to promote urine excretion.[19] This is especially efficacious during long pump runs when free plasma hemoglobin may rise significantly and result in hemoglobinuria. Although mild degrees of hemoglobinuria are usually of no consequence, higher levels may produce acute tubular necrosis.

Late Postoperative Period

The common complications during this period are related to disturbance of renal and hepatic function, cerebral ischemia and the postcardiotomy syndrome.

Renal Function.—This problem has been alluded to previously. Usually, the renal dysfunction is of a subclinical nature and is not grossly manifest unless looked for carefully. On review of postoperative charts it is common to note that although the patient maintains an adequate urinary output, polyuria occurs 10-14 days after surgery and is associated with a decrease in the blood urea nitrogen level. This, associated with the findings of casts and proteinuria in the early postoperative period, seems to be an indication of a mild state of acute tubular necrosis. In the occasional patient who develops classic acute tubular necrosis, therapy is similar to that required for the treatment of this syndrome following other more common etiologies.

Hepatic Function.—Hepatic dysfunction may result from homologous serum hepatitis, although this is usually not seen until late in the postoperative period. The severity of the hepatitis varies from mild to very severe and may result in postnecrotic cirrhosis. More common than hepatitis, and occurring earlier, is the postpump syndrome.[20] This syndrome begins two to four weeks after operation and is characterized by fever, hepatosplenomegaly, and atypical lymphocytes. Patients of any age and with any lesion, either acquired or congenital, may be affected. In our experience, the hepatic function is not significantly altered. There may be a slight increase in the bilirubin fractions, thymol turbidity, cephalin flocculation and the BSP retention, but these have always resolved spontaneously. The hepatosplenomegaly also usually resolves spontaneously, but may persist for indefinite periods. The cause of this syndrome is unknown, but recent demonstration that lymphocytes and monocytes may remain mitotically active, even in bank blood stored at 4°C. for two to three weeks,[21] has raised the interesting possibility of a graft vs. host reaction associated with reticuloendothelial cell hyperplasia resulting in lymphadenopathy and hepatosplenomegaly. We know of no biopsies of the liver or other lymphoid tissue following pump procedures, so that the actual architectural change is unknown.

Cerebral Function.—Varying degrees of cerebral ischemia may occur during cardiopulmonary bypass.[22,23] Postoperative paralysis, slow cerebration, and blindness have all been seen and have been noted to resolve spontaneously. Personality changes are not uncommon following cardiac surgery.[24,25] In our series, four adult patients experienced temporary schizophrenic reactions starting three to six days after surgery. These uniformly consisted of delusions, auditory and visual hallucinations and disorientation. All responded within four to seven days to phenothiazine therapy. Premorbid maladjusted personality and cerebral edema caused by cerebral anoxia due to inadequate perfusion are thought to be the most likely cause of these transient emotional and physical changes.

Postcardiotomy Syndrome.—This syndrome may have its onset two to six weeks after operation and is characterized by fever, pleural or pericardial pain, pleural or pericardial friction rubs, effusions and pulmonary infiltrates.[26] It is thought to be a hypersensitivity reaction. The treatment is generally symptomatic, although occasional cases receive steroid therapy which sometimes appears to be of benefit. Early postoperative mobilization is useful in helping to avoid pulmonary atelectasis and thrombo-embolic phenomena. However, McGuinness and Taussig[27] point out that strict limitation of activity should be enforced when early indications of the postcardiotomy syndrome are present to reduce the severity of the episode and reduce the likelihood of recurrences.

Arrhythmias.—Many patients with sinus rhythm preoperatively develop atrial fibrillation following surgery. Conversion from atrial fibrillation to sinus rhythm is worthwhile from a functional standpoint in patients with valvular heart disease and is especially indicated after successful mitral commissurotomy.[28] The conversion of atrial fibrillation is begun ten days postoperatively in all patients who have atrial fibrillation regardless of the duration of this arrhythmia. Any of the quinidine preparations may be utilized although we have found that quinidine polygalacturonate seems better tolerated by most patients. Previous anticoagulation prior to the institution of quinidine therapy seems to be ineffective in preventing embolization, and therefore, is not employed.[29] If the patient

has not converted to a normal sinus rhythm following moderate dosage, further efforts to convert the rhythm are delayed since in some cases this is easily accomplished several months after surgery whereas it is difficult in the immediate postoperative period.

Summary

The successful care of cardiovascular surgical patients requires a multi-disciplined team effort in which the internist is an active participant. Areas of difficulty arise in the postoperative period requiring specialized knowledge which is not ordinarily part of the surgeon's working armamentarium.

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Experimental Use of Autologous Aponeurotic Patches in the Repair of Atrial Septal Defects

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Alfred H. F. Lui, M.D.
Wayne W. Glas, M.D.
Pelayo B. Cabrera, M.D.
James J. Kivlahan, M.D.

Eloise, Michigan

ATRIAL septal defects have been repaired under direct vision frequently in many cardiovascular centers since Lewis and Taufic reported their successful case in 1953.[1] Although many atrial septal defects can be repaired by direct suturing alone, patches are necessary for closure of large defects. Ivalon[2,3] and teflon[4] have been used in the repair of intracardiac defects. Although these plastic materials are highly inert, the threat of bacterial endocarditis is always present. While this is infrequent, its presence endangers life.

It is logical that the use of autologous patches instead of foreign prosthesis would diminish if not circumvent this complication. Autologous pericardial patches have been used to repair intracardiac defects.[5,6] An experimental study utilizing another type of autologous patch was done and is the subject of this report.

Method

Thirteen dogs weighing 9 to 24 kilograms were operated upon with complete cardiopulmonary bypass using the Kay-Cross rotating disc oxygenator and occlusive roller pumps. Initial heparinization was carried out with approximately 3 mg. of heparin/kilogram of body weight. Perfusion rates of approximately 100 ml./kilogram/minute were used. The right atrium was approached through a right thoracotomy incision. The superior and inferior vena cavae were cannulated through the right atrium and venous blood was allowed to flow directly into the oxygenator by gravity siphonage. In the majority a 1:1 flow of oxygen to blood into the oxygenator was used. This resulted in 100 per cent arterial oxygen saturations in those cases in which arterial oxygen saturations were determined, and in 220 mm. Hg. to 405 mm. Hg. oxygen tensions in those cases in which oxygen tensions were measured. Oxygenated blood was returned to the animal through a cannula in the femoral artery.

The atrial septum was exposed through a longitudinal incision and a defect was made by excising a portion of the atrial septum. The defect was repaired with a free autologous aponeurotic patch obtained from the tendinous portion of the diaphragm. The average patch was approximately 15 x 20 mm. Histological studies were carried out at varying intervals or at death. Four animals died on the day of operation and were excluded from this study.

Results

Significant factors contributing to death in four dogs which died on the day of operation were hemorrhage in one, pulmonary edema from overtransfusion in one, excessive anesthesia in one, and unexplained in one dog which remained comatose till death. Three other dogs died 10 days, 24 days, and three months and 14 days postoperatively. Death was attributed to pulmonary edema, empyema, and empyema with pericarditis, respectively. The remaining six dogs were sacrificed at intervals ranging from approximately two to seven months after operation. Specimens were thus available for study at the following intervals postoperatively: 10 days, 24 days, two months and five days, two months and 11 days, three months and 14 days, four months, five months and two days, six months, and seven months.

None of the nine aponeurotic patches had any vegetations to suggest the presence of bacterial endocarditis. One of the nine patches examined 24 days postoperatively was associated with a thrombus approximately 1 x 1 x 2 cm. This was adherent to a portion of the patch and extended to the adjacent

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From the Department of Surgery and Pathology, Wayne County General Hospital, Eloise, Michigan.

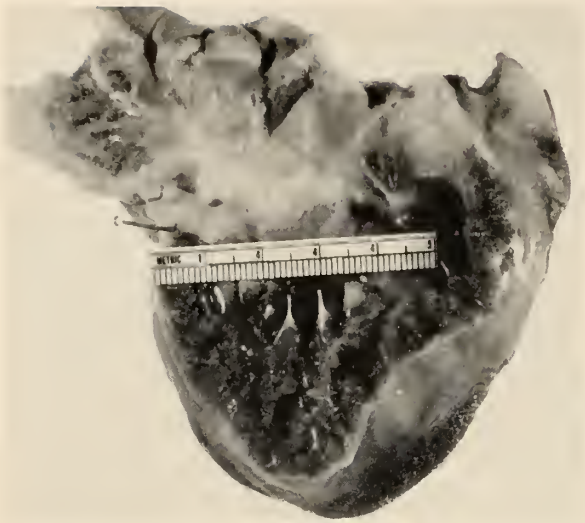


Fig. 1. Six months after repair of atrial septal defect using a free autologous aponeurotic patch. Note smooth whitish thickening in area of repair located just above metric ruler.

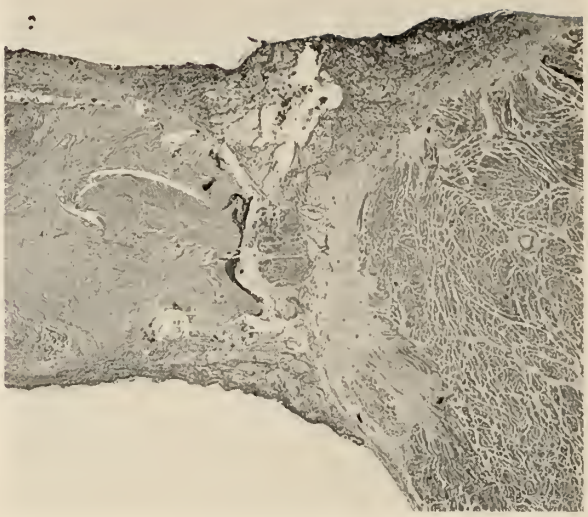


Fig. 2. Cross section of junction of free autologous aponeurotic patch *(left)* with atrial septum magnified 23 ×. Note the organizing fibrinous membrane covering both surfaces of the collagenous aponeurotic patch. Specimen examined 10 days after operation.

atrial wall superiorly. Because it was not limited to the patch, it was believed that this was due to operative trauma rather than to the patch. In one heart examined four months postoperatively, a nodular cartilaginous mass approximately 0.75 x 0.75 x 1.5 cm. was present at the cephalad end of the aponeurotic patch on its right atrial surface. This was believed to be a result of operative trauma, perhaps peculiar to the dog. All aponeurotic patches were significantly thickened as pictured in Figure 1.

Paraffin sections were made using hematoxylin and eosin, periodic acid Schiff, Verhoeff's elastic and trichrome stains. Examination 10 days postoperatively showed that the aponeurotic patch was covered on both sides with an organizing fibrinous membrane (Figs. 2 and 3). A layer of spindle shaped cells devoid of a supporting elastic membrane lined the fibrinous membrane on its endocardial surfaces. When examined 24 days postoperatively, the graft was covered by vascular granulation tissue. Few chronic in-



Fig. 3. Higher magnification (110 ×) of specimen as seen in Figure 2. Note the organizing fibrinous membrane (*upper* ¾) covering the collagenous aponeurotic patch (*lower* ¼).



Fig. 4. Area of cartilaginous metaplasia located in fibrous tissue covering the patch which had been inserted three months and 14 days previously. Magnified 100 ×.



Fig. 5. Section of specimen examined 6 months after operation demonstrating the single layer of flat endothelial-like cells lining the homogeneous fibrous layer which covers the aponeurotic patch *(not shown)*. The absence of an elastic basement membrane supports the belief that these cells are derived from the blood rather than from adjacent endocardium. Magnified 440 ×.

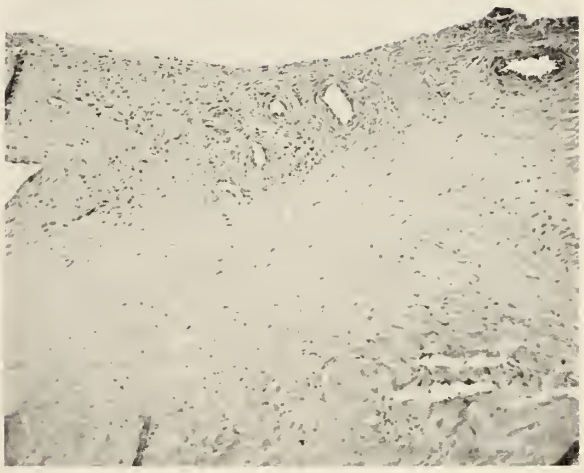


Fig. 6. Specimen seven month postoperatively showing vascular channels in the fibrous tissue which covers the patch. Note the excellent union between the fibrous tissue and the aponeurotic patch as shown in the lower third. Magnified 100 ×.

flammatory cells were seen at the edges of the repair. An area of cartilaginous metaplasia was seen in the specimen examined two months and five days postoperatively. The homogeneous collagenous graft was covered on both sides by fibrous tissue lined by spindle shaped cells devoid of a supporting elastic membrane. A moderate chronic inflammatory reaction was present at the edges of the graft. Figure 4 demonstrates an area of cartilaginous metaplasia in a specimen examined three months and 14 days postoperatively. This was located in the fibrous tissue covering the patch. Cartilaginous metaplasia was also seen to extend a considerable distance beyond the edges of repair, suggesting that this was probably due to operative trauma rather than to the patch. The patch was represented by homogeneous collagenous tissue covered by thick fibrous tissue which was lined on its endocardial surfaces with a layer of spindle shaped cells.

Specimens examined four, five, and six months postoperatively showed similar findings to that examined at three months and 14 days postoperatively. Figure 5 demonstrates the endothelial-like cells which formed the endocradial lining of the aponeurotic patch in a specimen examined six months postoperatively. There is no underlying elastic basement membrane supporting the belief that the endothelial-like cells lining the endocardial surfaces of the aponeurotic patch are derived from the blood rather than from adjacent endocardium. Examination of the specimen obtained 7 months postoperatively showed that the endothelial-like cells covering the aponeurotic patch was still without a supporting elastic basement membrane. Cartilaginous and osseous metaplasia were seen around suture material. Widely patent vascular channels in the fibrous tissue are illustrated in Figure 6. All patches showed firm healing at the area of anastomosis. This has also been noted by Iwa, et al,[7] when autologous diaphragmatic aponeurosis was used experimentally as a gusset in the outflow tract of the right ventricle.

Discussion

In order to evaluate the feasibility of using free autologous aponeurotic patches to repair atrial septal defects, an experimental study was performed in 13 dogs. With the aid of complete cardiopulmonary bypass, atrial septal defects were made and repaired by using free autologous aponeurotic patches obtained from the tendinous portions of the diaphragm. In addition to its autologous nature and its being readily available, aponeurotic patches were found to be pliable, strong, and easy to suture. There was no fraying of the edges of the patch.

One of the hearts had a thrombus on the patch. Because this was adherent to a portion of the patch

and also extended to the adjacent atrial wall superiorly, it was believed that this was due to operative trauma rather than to the nature of the patch. This thrombus was present only on the right atrial surface. One patch was associated with a large nodule of cartilaginous metaplasia which was located at the superior edge of the repair. This was attributed to operative trauma, perhaps peculiar to the dog. There were no vegetations on any of the patches to suggest the presence of bacterial endocarditis.

Histologic studies showed that the aponeurotic patches were covered on both sides with a fibrinous membrane which became organized. These layers of fibrous tissue were lined with endothelial-like cells on the endocardial surfaces. In none of the specimens was the elastic basement membrane seen to extend over the aponeurotic patch supporting the belief that the endothelial-like cells lining the patch were derived from the blood rather than from adjacent endocardium. In six of the nine hearts cartilaginous metaplasia was found. These changes were believed to be a response to operative trauma, perhaps peculiar to the dog.

These experimental studies have shown that free autologous aponeurotic patches in an intracardiac location are tolerated satisfactorily by the dog. The elimination of a foreign prosthesis and with it the problem of sterilization and the threat of bacterial endocarditis, the ready availability of aponeurotic patches, the ease of suturing, the strength, the pliability, and the lack of fraying of the edges are all significant advantages to be considered in the selection of a patch for the repair of intracardiac defects.

Summary

Atrial septal defects were made and repaired with free autologous aponeurotic patches in 13 dogs. Nine animals were available for study from periods varying from 10 days to seven months postoperatively. These patches were covered with fibrinous membranes which became organized. A single layer of endothelial-like cells formed the endocardial lining. The elastic basement membrane did not extend over the patch from the adjacent endocardium even at seven months after operation; supporting the belief that the endothelial-like cells were derived from the blood rather than from adjacent endocardium. There were no vegetations on any of the patches to suggest the presence of bacterial endocarditis. One patch was associated with a thrombus. This was adherent to a portion of the patch and was also adherent to the adjacent atrial wall superiorly. Because it was not limited to the patch it was believed to be due to the trauma of operation rather than to the patch. Six of the nine hearts showed areas of cartilaginous metaplasia. These changes were believed to be a response to operative trauma, perhaps peculiar to the dog.

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Acknowledgment

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Serum Creatine Phosphokinase Activity

A New Diagnostic Aid in Myocardial And Skeletal Muscle Disease

Joseph W. Hess, M.D.
Roderick P. MacDonald, Ph.D.
Detroit, Michigan

IN RECENT YEARS, clinical enzymology has become increasingly important in everyday medical practice. Enzymes of intracellular origin can be measured with relative ease in blood serum, and elevations of serum enzyme activity often correlate with parenchymal disease. This gives the physician a means of assessing indirectly the presence or absence, and to a degree the activity, of various disease states. Careful observation of the patterns of enzyme elevation in conjunction with other clinical observations have significantly extended the clinician's ability to accurately detect a wide variety of disease processes.

As knowledge of basic biochemistry has increased, new and important additions to the battery of laboratory studies available to the clinician have been developed. However, each new diagnostic test which appears raises certain questions. Does it give information not available through studies already in use, and is it specific enough to be of value in differential diagnosis? Is it practical and adaptable to clinical medicine, or primarily of research interest?

With these questions in mind, we have evaluated over the past year and a half the potential usefulness of serum creatine phosphokinase (also called creatine kinase, ATP-creatine phosphotransferase, and ATP-creatine transphosphorylase) activity as a diagnostic aid in diseases affecting heart and skeletal muscle. We originally became interested in this enzyme because available data suggested that it is normally present in very minimal concentrations in human serum and is found in high concentrations primarily in striated muscle.[1] Elevation of serum creatine phosphokinase (CPK) activity therefore should be a more specific indication of damage to muscular tissue than widely distributed enzymes such as glutamic oxaloacetic transaminase (GOT) and lactic dehydrogenase (LDH).

Serum CPK activity was introduced as a diagnostic aid in human disease in 1959 by Ebashi and coworkers in Japan,[2,3] and in 1960 by Dreyfus and associates in France.[4,5] At the time our studies began, no thorough clinical evaluation of this enzyme test by workers in this country had appeared in the literature, although there had been considerable interest among European workers.[6,7,8] Interest in this enzyme appears to be increasing, however, and in the near future it should be possible to evaluate the experience of a number of laboratories in the United States as well as elsewhere.

Our data, part of which is presented here, suggests that serum CPK activity does show greater sensitivity and specificity for detecting myocardial and skeletal muscle damage than commonly determined enzymes such as LDH and GOT. Other serum enzymes such as aldolase, alpha-hydroxybutyric dehydrogenase, phosphohexose isomerase and malic dehydrogenase, which have been used as indices of striated muscle disease, are also widely distributed and lack tissue specificity.

Materials and Methods

Creatine phosphokinase catalyzes the reversible transfer of a high energy phosphate group from ATP to creatine according to the reaction:

$$\text{ATP} + \text{Creatine} \overset{\text{CPK}}{\rightleftarrows} \text{ADP} + \text{Creatine phosphate}$$

The optimum pH for the forward reaction is 9 and for the reverse reaction is 7.2. The method used for assaying serum creatine phosphokinase activity in

From the Department of Medicine, Wayne State University College of Medicine and the Departments of Medicine and Pathology, Harper Hospital, Detroit, Michigan. This study was supported by research grants from the Michigan Heart Association and Muscular Dystrophy Associations of America, Inc.

these studies was that of Tanzer and Gilvarg[1] in which the primary reaction is coupled with two subsequent reactions according to the scheme:

$$\text{ATP} + \text{Creatine} \xrightleftharpoons{\text{CPK}} \text{ADP} + \text{Creatine phosphate}$$

$$\text{ADP} + \text{Phospho-enolpyruvate} \xrightleftharpoons{\text{PK*}} \text{pyruvate} + \text{ATP}$$

$$\text{Pyruvate} + \text{DPNH} \xrightleftharpoons{\text{LDH}} \text{Lactate} + \text{DPN}$$

The rate of oxidation of DPNH measured spectrophotometrically at 340 millimicrons is proportional to the CPK activity of the serum. One ml of serum is used in the reaction mixture and the rate of activity is followed for ten minutes. The reagent blank is identical to the unknown, except for the omission of the specific substrate, creatine.

Reagents used in these studies were prepared in kit form by the West German firm of C. F. Boehringer and Sons and were obtained through their U. S. distributor, the California Corporation for Biochemical Research, 3625 Medford Street, Los Angeles 63, California. The technique is relatively simple, requires about 30 minutes to complete, and may be performed by any competent laboratory technician. A Beckman DU spectrophotometer was used to measure the change in absorbance. Satisfactory colorimetric methods are also available;[10,11,12] however unless one anticipates a large volume of determinations, the reagent kit method is the simplest to set up if a sensitive spectrophotometer capable of measurements in the ultraviolet range is available.

Definition of Units.—A variety of units have been described for CPK activity. We prefer unitage based on the International Unit system recommended by the International Union of Biochemistry.[9] According to this recommendation, one International Unit is that amount of enzyme which will catalyze the transformation of one micromole of substrate per minute under specified conditions. Based on this system and the reaction scheme outlined above, one International Unit is that amount of CPK activity which will lead to the oxidation of one micromole of DPNH per minute per milliliter of serum at pH 9.0 and 25°C. For practical clinical use, we believe that the International Unit should be multiplied by a factor which will make it possible to express the range of values encountered in clinical medicine in terms of whole numbers significant to the last digit. The range of normal serum CPK activity is from 0 to .0007 micromoles DPNH oxidized per minute per milliliter of serum. We recommended that the International Unit be written x 10^{-4} so that the normal range of CPK activity would be expressed as 0 to 7 (x 10^{-4}) International Units per milliliter of serum. In clinical practice, the factor 10^{-4} could be omitted except when comparison with, or conversion to, other enzyme units is desired. Expression of units in such a way that the figures may be rounded off to the nearest whole number with the last digit being significant has several important advantages: (1) It circumvents the inaccuracies of a faint, misread or misplaced decimal point on the laboratory report. (2) Laboratory test results, particularly in terms of ranges of normal and abnormal for new tests, are more easily learned and retained and are more apt to be interpreted properly when expressed in round numbers. (3) If, under special circumstances conversion to International Units per liter or other unit volume is desired, this may be done by simply changing the exponent.

*Pyruvate kinase.

Results

Technical Considerations.—Considerable data has been accumulated on the laboratory aspects of the CPK determination, part of which is summarized here. The determinations should be performed within three hours following venipuncture, since we have observed variable decreases in activity when the serum is held for longer periods. Contrary to reports regarding rabbit muscle CPK,[13] we have found that CPK in human serum is quite labile. Storage for 24 hours or longer of frozen serum from patients with acute myocardial infarction decreased the CPK activity by one-fourth to one-half. Skeletal muscle CPK appears to be more stable when frozen. These differences suggest the presence of isoenzymes of CPK, a question currently under investigation in this laboratory. We have also found that heating serum at 56° for 15 minutes inactivates the enzyme whether obtained from patients with heart or skeletal muscle disease. Heat inactivated serum is the best diluent when it is necessary to dilute serum samples with high CPK activity. Distilled water used as a diluent produces slight inactivation, though not as much as normal saline.

Serum CPK Activity in Normal Subjects.—Statistical analysis of a series of serum samples from 59 normal, non-hospitalized subjects aged 15 to 75 years, gave a normal range (95 per cent limits based on a log-normal distribution) of 0 to 6 (x 10^{-4}) International Units per ml of serum. This finding when converted to International Units is in essential agreement with the upper limit of normal proposed by Foster[6]

We agree therefore with a practical normal range of 0 to 7 (x 10^{-4}) International Units as recommended by the supplier of the reagent kits, with the area between 7 and 10 (x 10^{-4}) units being considered equivocally abnormal. This is in accordance with our belief that there is no sharp line of demarcation between normal and abnormal serum enzyme values. Our data revealed no apparent age or sex difference, although Hughes, using a colorimetric method, found slightly higher levels in males.[10]

Serum CPK Activity Following Myocardial Infarction.—Serum CPK activity begins to rise within a few hours following the onset of symptoms of acute myocardial infarction and generally reaches a peak in approximately 36 hours. Thereafter there usually is a rapid return to normal by the second to fourth day. The duration of elevation is similar to that of GOT, but less than that of LDH, although considerable variation may be seen in individual patients. A characteristic enzyme pattern is shown in Figure 1. The magnitude of peak elevation following myocardial infarction is usually higher for CPK than that observed for GOT or LDH. Data on 31 patients with myocardial infarction confirmed by typical electrocardiographic patterns show that the mean peak elevation of CPK was 11.0 times the upper limit of normal, as compared to 4.2 fold for GOT and 3.6 fold for LDH. This suggests that greater relative amounts of CPK are released into the circulating blood per unit weight of infarcted myocardium than is true for the other two enzymes.

In a group of 22 patients with a history of chest pain compatible with the diagnosis of coronary insufficiency and/or myocardial infarction, and in whom the electrocardiogram showed ischemic changes but lacked a characteristic infarct pattern, it was found that serum CPK activity was elevated in 68 per cent, whereas GOT was elevated in 35 per cent and LDH was elevated in 32 per cent. These figures suggest that serum CPK activity is a more sensitive indication of anoxic myocardial damage than are the activities of GOT or LDH. Since the electrocardiogram often will indicate no more than slight changes in ST and T wave configuration with those infarctions which involve only a thin layer of ventricular wall, measurement of serum CPK activity would seem to extend one's ability to detect small areas of infarction.

Serum CPK activity has been normal in all patients with congestive heart failure and no clinical evidence of recent myocardial infarction studied to date. Elevation of GOT and LDH in patients with congestive heart failure is probably due to congestive changes in the liver.[14] Serum enzyme elevation following shock may be of multiple organ origin, including liver.[15]

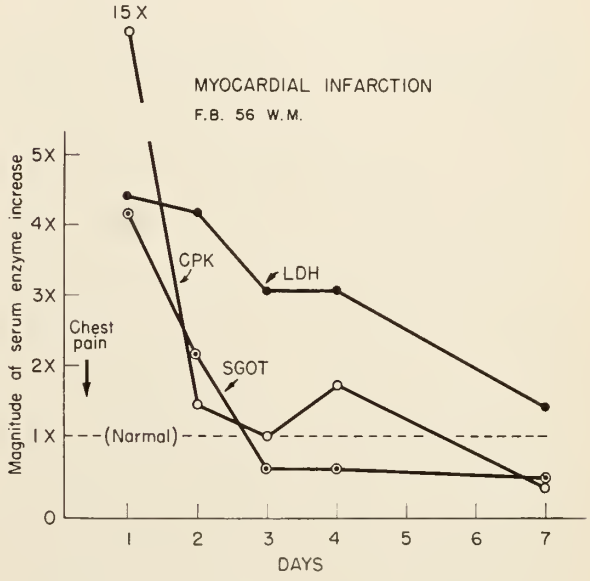


Fig. 1.

CPK and Muscle Disease.—The highest values for serum CPK activity in our studies have been encountered in patients with Duchenne type progressive muscular dystrophy. In this disease, there is widespread active disintegration of skeletal muscle. A wide range of values have been encountered in these patients, with some individual values in excess of 200 times the upper limit of normal. In a group of 20 patients with muscular dystrophy, the mean magnitude of elevation of serum CPK activity was 59.3 fold as compared to 3.1 fold for LDH and 2.3 fold for GOT. High levels have also been found in patients with active polymyositis. Patients with myotonic dystrophy studied thus far have had only mild elevations or were normal. Normal levels have been observed in patients with myasthenia gravis and with muscular weakness due to thyrotoxicosis.

Muscle trauma, including surgery, will produce increases in serum CPK activity, the degree depending upon the extent of muscle injury. Frequent intramuscular injections of irritating drugs such as aqueous penicillin may also produce serum CPK elevations up to four or five times normal, but occasional injections of narcotics, diuretics, and barbiturates appear to have no detectable influence. In general, serum CPK activity tends to remain elevated longer than GOT and

LDH in conditions of limited duration affecting skeletal muscle. This is in contrast to the usual pattern following myocardial infarction where CPK returns to normal quickly and there is prolonged elevation of LDH.

Serum CPK Activity and Other Disease States.—Serum CPK activity has been determined on patients with diseases involving a variety of organs and tissues other than striated muscle. Many of these conditions are associated with elevation of serum LDH and/or GOT activities as well as a variety of other enzymes. Of particular interest are those clinical situations which are frequently associated with elevations in GOT and LDH, and which may accompany or co-exist with diseases of the heart or skeletal muscle. Fifteen patients with liver disease, including acute infectious hepatitis, cirrhosis, and acute yellow atrophy, all had normal CPK activity. All of these patients had elevated GOT activity, and LDH was elevated in those patients on whom it was determined. The lack of elevation of serum CPK activity is consistent with our observation that human liver homogenates contain no detectable CPK activity.[17] The serum CPK was also normal in seven patients with hemolytic anemia and pernicious anemia in relapse, all of whom had elevated LDH activity.

We thus far have data on only four patients with pulmonary emboli, and two of these had slight elevations of CPK activity. From our tissue homogenate data, we know that neither lung tissue nor red blood cells contain appreciable amounts of CPK.[17] We therefore are inclined to ascribe these slight CPK elevations following pulmonary emboli to myocardial anoxia. CPK activity was within normal limits in five patients with chronic pulmonary disease, four with chronic renal disease and azotemia, five with solid tumors, and two with peptic ulcer.

Graig and Ross recently reported elevation of serum CPK activity in patients with hypothyroidism.[18] We have not had the opportunity as yet to adequately study this problem, but hypothyroidism as a possible cause of elevated serum CPK should be kept in mind.

False Positives and False Negatives.—We have encountered occasional instances where serum CPK activity was elevated and the reason was not immediately evident. This has occurred infrequently, and often has been accompanied by elevation of other serum enzymes or other laboratory abnormalities which also were unexplained. These we do not consider as false positives, but rather as unexplained elevations. There may be occasional difficulties in interpreting the meaning of an elevated CPK, as illustrated by the following case history.

A 65-year-old white man was awakened at 2:30 A.M. by nausea, vomiting and chest pain, and was admitted to the hospital with the diagnosis of probable myocardial infarction. Electrocardiogram on admission showed minimal ST and T wave changes in standard lead 3, and diphasic T waves in precordial leads V1 and V2. A repeat electrocardiogram the following day was normal. Serum CPK activity was 27 and 32 (x 10^{-4}) International Units per milliliter on the first and second hospital days respectively, whereas the LDH and GOT were normal. Following admission, he developed fever and his pain shifted to the right upper quadrant. Subsequently, a gangrenous gallbladder was removed at surgery.

In this case, we were uncertain as to whether the elevation was due to a small myocardial infarction or whether gangrene of the smooth muscle of the gallbladder was sufficient to produce an elevation. We have found that human gallbladder homogenates do possess a small amount of CPK activity, but whether there is enough to produce elevated serum CPK activity when the entire organ undergoes necrosis is uncertain at this time.

One apparently false positive CPK was recorded on a patient who was later proven to have carcinoma of the pancreas. Determinations on two subsequent days were within normal limits, however.

We have encountered occasional examples of what appeared to be false negatives, but on closer examination in all instances studied thus far, the false negative results could be explained by improper timing or storage of blood samples.

Summary and Conclusions

Serum CPK activity has been studied in a variety of clinical situations. It has been found to be a more specific and sensitive indicator of injury or disease of heart and skeletal muscle than other serum enzymes currently in use. Its chief disadvantages from the clinical standpoint are the relative short period of elevation (two to four days) following myocardial infarction and the labile nature of the enzyme when serum is stored, particularly CPK of myocardial origin.

Serum CPK is of equal or greater value than GOT for routine diagnostic confirmation of myocardial infarction. It possesses greater specificity than LDH but has a shorter duration of elevation. In the presence of pulmonary infarction, hepatic congestion, hepatic hypoxia associated with shock, or active primary liver disease, serum CPK activity is a far clearer indication

of the presence or absence of acute myocardial necrosis than are LDH or GOT.

Techniques currently available do not permit differentiation between myocardial and skeletal muscle CPK activity in the serum. We are currently investigating this possibility. At present this differentiation must be made on clinical grounds alone. It should be remembered that frequent intramuscular injections of irritating substances do release significant amounts of intramuscular enzymes into the extracellular fluid. Because skeletal muscle possesses high CPK activity, this source of factitious elevation must be kept in mind.

In conclusion, when serum CPK activity is understood and used properly, it can become an important diagnostic aid to the physician in clinical practice.

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Heart Failure of Uncertain Etiology

Sunil K. Das, M.D.
William S. Wilson, M.D.
Ann Arbor, Michigan

IT IS USUALLY easy to make an etiologic diagnosis in a patient who presents with heart failure or other overt evidence of heart disease. The list of common etiologic agents is short (Table I) and in the overwhelming majority of patients with heart disease, one can confidently incriminate one or more of these processes. The purpose of this paper is to discuss one aspect of the problem presented by the occasional patient who has obvious heart disease (usually manifested by failure) in whom it is extremely difficult or impossible to make a confident etiologic diagnosis after a thorough clinical, radiologic and electrocardiographic examination.

We have had the opportunity to observe and study 45 patients who presented as heart disease of uncertain etiology and have selected the twenty-two patients listed in Table II for discussion because an etiologic diagnosis is now available from autopsy examination or from definitive physiologic studies.

A perusal of Table II confirms the prevailing opinion that many of these puzzling patients have rare or uncommon etiologic types of heart disease (amyloidosis, myxoma, metastatic neoplasm, primary myocardial disease, et cetera). A discussion of the long list of rare types of heart disease is not our purpose, and the interested reader is referred to the standard textbooks and to recent reviews of this topic.[1,2] The purpose of this paper is to discuss the fact that the common etiologic agents are also well represented in this group of patients (seven patients with either arteriosclerotic, congenital or rheumatic heart disease), since there is a tendency in many of us to emphasize the rare and the exotic when confronted with a difficult diagnostic problem.

The three patients (Table I: L.P., N.R., S.M.) who were found at autopsy to have severe arteriosclerotic heart disease are of particular interest. Each of these patients presented with heart failure, and the diagnosis of arteriosclerotic heart disease was not the major consideration because of the absence of angina pectoris and the lack of electrocardiographic changes of myocardial infarction. In addition, such predisposing factors as hypertension, obesity, diabetes mellitus and hypercholesterolemia were absent.

TABLE I. USUAL ETIOLOGIC TYPES OF HEART DISEASE

Arteriosclerotic	Congenital
Hypertensive	Pulmonary
Rheumatic	Luetic

There were four other patients in the group who had the usual types of heart disease. In the two patients who were subsequently found to have coarctation of the aorta (Table II: D.B., M.R.), the clinical diagnosis was obscured largely because each of them had severe pulmonary arterial hypertension secondary to chronic left ventricular diastolic hypertension. Because of this secondary pulmonary hypertension, they presented in a rather unusual manner—in severe right ventricular failure. Rib notching was absent, and the presence of edema made it difficult, even in retrospect, to evaluate the lag in the femoral pulse. In one patient both subclavian arteries arose distal to the coarctation so that the pulse lag was apparent only on simultaneous palpation of the carotid and femoral arteries. The correct diagnosis was made only after cardiac catheterization and angiography. The two patients with rheumatic heart disease also presented in an atypical manner. C.H. had obvious heart failure and only a soft apical and basal systolic murmur, thought most likely to be of no significance. The diagnosis of aortic stenosis was made only at autopsy. F.S. had been followed with the diagnosis of pulmonary heart disease. The murmur of mitral stenosis had been repeatedly inaudible to several observers. The diagnosis was made on the basis of a left atrioven-

From the Department of Internal Medicine, (Heart Station) University of Michigan, Ann Arbor, Michigan.

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tricular gradient and confirmed at the time of successful surgery.

The presence of these seven patients in a group of patients with "heart disease of uncertain etiology" is of significance and should be instructive. It emphasizes several easily forgotten facts. Our criteria for making an etiologic diagnosis in patients with heart disease are largely indirect and, although they are remarkably accurate, they are not infallible. It is well to be reminded periodically that a minority of patients with arteriosclerotic heart disease will have neither angina pectoris nor electrocardiographic evidence of myocardial infarction and may present with only the non-specific syndrome of heart failure. Likewise, a few patients with rheumatic and congenital heart disease will present with atypical murmurs or perhaps with no murmur. When confronted with a patient with heart failure of uncertain etiology, it therefore seems wise to divide the diagnostic problem into two broad categories: rare types of heart disease (the list is long) and the "garden variety" usual types of heart disease presenting in an unusual manner. The absence of the typical diagnostic signs does not allow one to dismiss the usual etiologic agents. Since most of the patients with heart failure of uncertain etiology will be studied by cardiac catheterization, it is particularly important from a diagnostic point of view that the studies be planned with the possibility of "usual heart disease, unusual manifestations" in mind.

TABLE II.

Name	Age	Sex	Blood Pressure	Final Diagnosis
1. DB.	19	M	110/95	Coarctation of the aorta
2. M.R.	35	F	160/95	Coarctation of the aorta
3. J.B.	45	M	160/100	Primary myocardial disease
4. L.P.	39	M	100/70	Arteriosclerotic heart disease
5. D.K.	53	F	125/85	Primary myocardial disease
6. N.R.	54	M	120/80	Arteriosclerotic heart disease
7. M.S.	48	M	145/85	Primary myocardial disease
8. E.M.	49	M	90/70	Primary amyloidosis
9. C.H.	51	M	110/60	Tight aortic stenosis (valvular)
10. W.S.	38	M	120/70	Idiopathic hypertrophic subaortic stenosis
11. V.J.	47	M	120/80	Rheumatic endocarditis, myocarditis
12. L.A.	45	F	125/90	Endocervical carcinoma with metastases to pleura, pericardium
13. I.D.	32	F	120/90	Sarcoma of right atrium
14. K.S.	27	M	120/70	Primary myocardial disease
15. S.M.	56	M	130/80	Arteriosclerotic heart disease
16. A.W.	46	M	140/90	Left atrial myxoma
17. H.P.	33	M	120/75	Idiopathic hypertrophic subaortic stenosis
18. B.B.	62	F	180/100	Constrictive pericarditis
19. J.B.	15	M	124/60	Hemorrhagic pericardial effusion due to metallic foreign body
20. K.A.	44	F	120/80	Chronic pericardial effusion probably due to sarcoidosis
21. G.N.	48	F	140/90	Right atrial myxoma
22. F.S.	46	M	130/80	Mitral stenosis

The absence of the typical diagnostic signs does not allow one to dismiss the usual etiologic agents. Since most of the patients with heart failure of uncertain etiology will be studied by cardiac catheterization, it is particularly important from a diagnostic point of view that the studies be planned with the possibility of "usual heart disease, unusual manifestations" in mind.

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Nursing Education Study Under Way

The board of directors of the American Nurses' Association and the National League for Nursing have approved plans to initiate a full-scale study of nursing education as recommended in the Report of the Surgeon General's Consultant Group on Nursing.

The study will be made of the present system of nursing education in relation to the responsibilities and skill levels required for high-quality patient care.

The study will not be confined to investigation of defects in present systems of nursing education but will be pursued imaginatively and diligently, focusing on preparation for the comprehensive health care of the people and the role of nursing in this care.

External Electric Countershock Termination Of Refractory Supraventricular Tachycardia

C. Mark Vasu, M.D.
Larry H. Birch, M.D.
Grand Rapids, Michigan

MANY CLINICIANS have been challenged with the supraventricular tachycardia that seemed refractory to anti-arrhythmia drugs. With the introduction of external electric countershock therapy, many investigators have reported the remarkable ease of conversion of these persistent arrhythmias.[1,2] The clinical value of external electric countershock has been well established for the emergency termination of ventricular fibrillation or tachycardia.[3] It is our purpose to discuss some of the more important aspects of management. This type of conversion can be done on an elective basis and should follow, in most cases, a definite plan of operation.

In this study, there were ten patients with auricular fibrillation and six patients with auricular flutter. All patients were subjected to full therapeutic doses of digitalis and quinidine. Ten patients were given anticoagulants for four to six weeks prior to conversion attempts. None of the patients had had a recent myocardial infarction and none were in acute congestive heart failure. Because of persistent supraventricular tachycardia, cardiac output was obviously below par and this was one of the more important reasons for the conversion attempt. In all cases up to the point of this publication, we have had 100 per cent success in direct conversion to the normal sinus rhythm. During the past ten months, 70 per cent of these people still maintain a normal rhythm.

Procedure

The patients were hospitalized and continued on digitalis therapy. Quinidine was given in progressive doses of 200 to 600 mg. every two hours. Only two patients did not receive quinidine. (They had shown some allergic manifestations on a previous trial with this drug.) When we were sure that they would not convert on quinidine, the patients were scheduled for electric countershock therapy. We believe that this procedure must be done in an area where emergency supplies and equipment are instantly available. For that reason, we have done these cases in the post-surgical recovery room.

At this time, anesthetic management of these patients for electric conversion of a cardiac arrhythmia becomes extremely important. Certain principles that we have rigidly adhered to consist of the following: (1) the use of a nonexplosive anesthetic; (2) the agents and techniques used must not unduly depress the cardiovascular system; (3) we must be able to achieve excellent oxygenation and ventilation (the latter for removal of carbon dioxide); (4) we must help allay the patient's apprehension, thereby decreasing sympathetic activity; (5) we must permit rapid recovery of consciousness and muscle power; (6) any emergency drugs and equipment must be readily available.

The anesthesiology staff has outlined the following program for premedication: Meperidine (0-100 mg.) plus atropine or scopolamine (0-0.4 mg.) and in one patient, phenergan 25 mg. In regard to the premedication, ideally these agents should be given in a dosage designed to minimize the patient's apprehension, yet not cause undue depression of respiration or circulation. Usually very modest doses of meperidine accomplished this nicely. A drying agent is included in the premedication to minimize secretions. Atropine is used if the patient appears reasonably calm, or scopolamine for additional psychic sedation, if the patient appears apprehensive. It seems best to give these agents intramuscularly from 45 to 90 minutes before the procedure. However, on several occasions, unexpected delays extended this time to as much as 130 minutes and in two patients medications were given intravenously a few moments before the procedure.

The anesthetic agents used were: Thiamylal sodium (Surital), succinyl choline or decamethonium bromide

From Butterworth Hospital, Grand Rapids, Michigan.
This work was done under a grant from the Michigan Heart Association.

(Syncurine), nitrous oxide, oxygen or fluothane (Halothane) plus oxygen. In regard to the anesthetic technique, an intravenous injection is started and the apparatus well secured. Generally, a plastic needle is used to minimize the chance of the intravenous injection apparatus being dislodged at a crucial moment. The patient breathes a high oxygen atmosphere for a few moments before the procedure. This can be either straight oxygen, nitrous oxide and oxygen or nitrous oxide and fluothane plus oxygen mixture. In any event, oxygen saturation is higher than the atmosphere, generally 50 per cent or more, to insure more than adequate oxygenation. Respiration is assisted and/or controlled to assure adequate pulmonary excretion of carbon dioxide. An ultra-short acting barbiturate (Surital) is used intravenously just before the procedure to insure amnesia. This can be given before the mask is applied if the patient is apprehensive, or just before the electric shock. An intravenous muscle relaxant has been used in most of our cases, both to facilitate good ventilation with the anesthesia machine and to try to minimize the severe muscular contractions associated with the shock. This has no effect in reducing contraction of muscle from direct electrical stimulation, but may help to reduce contractions due to nerve stimulation. Maximum doses of the anesthetic drugs have been: surital, up to 300 mg; syncurine up to 3 mg.; and succinyl choline up to 100 mg. (this is by far the largest dose used; the second largest dose was 40 mg.). We have also given 200 to 400 mg. of quinidine intramuscularly two hours before the procedure.

When the appropriate plane of anesthesia was obtained, electric countershock was given with the application of 100 to 300 watt-seconds of direct current[4] using standard equipment designed for this purpose.* The patient was monitored throughout the procedure and electric countershock was given in a manner similar to the well-described procedure for the treatment of ventricular fibrillation.[5] After electric shock, ventilation with oxygen was continued until adequate spontaneous ventilation had returned.

Results

These patients were divided into three categories: arteriosclerotic heart disease, rheumatic heart disease and congenital heart disease.[6] Two patients did not fit into any of the above categories, one having had a recent pneumonectomy for carcinoma of the lung. The other was a young man with idiopathic auricular fibrillation. The age group was from 22 to 73 and included as noted above, ten cases of auricular fibrillation and six cases of auricular flutter. In all cases after electric countershock therapy there was a conversion to a normal sinus rhythm, using anywhere from one to three electric countershocks. In most cases, conversion was immediate after the first shock. All of these individuals were placed on maintenance quinidine therapy. If there was a manifest hypersensitivity to this drug, pronestyl (procaine amide) was the alternate drug of choice.

All 16 individuals have been followed for approximately ten months. In five patients we have noted an inability to maintain a normal sinus rhythm despite high doses of quinidine therapy. We elected to maintain all the patients on 400 mg. of quinidine every six hours and despite these doses, they reverted to their previous arrhythmia. In only one case, that of a 66-year-old white woman with rheumatic heart disease and severe congestive failure, were we unable to maintain a normal rhythm for more than two hours after electric conversion. In none of these cases did we experience any complications of peripheral emboli.

With regard to complications, one patient developed a ventricular tachycardia and another a ventricular fibrillation, both shortly after intravenous succinyl choline. The patients were treated promptly with further shock which restored a normal sinus rhythm.[7] It has also been apparent that there is a potentiation in prolongation of the effect of succinyl choline in patients who received either quinidine or procaine amide.[8] Several patients required ventilatory assistance until they recovered their muscle activity in ten to fifteen minutes. One patient had generalized aching discomfort the day after electric conversion. This was probably the result of rapid administration of succinyl choline with muscle fibrillation before paralysis ensued.

We believe that making this an elective procedure and insisting upon the use of anticoagulants for at least four to six weeks prior to conversion attempts has some beneficial effect. However, as mentioned previously, six of these patients did not receive anticoagulants. These were patients whose arrhythmia had had an acute onset. In those who have had the arrhythmia for as long as two years, anticoagulation is imperative before attempting conversion. In two cases the patients reverted to their previous arrhythmia but seemed to be more easily converted on quinidine alone. This observation is entirely clinical.

*Lown Cardioverter

Discussion

It appears that no single group holds an advantage over another in the use of electric conversion. In all cases, it was effective almost immediately. On a few occasions, an increase in voltage in the application of the electric countershock became necessary. It has become clear to us that there are many ways of approaching this type of therapy from both the standpoint of the drug administration and anesthetic management. However, our goal was some definite program to be followed in order to insure that the procedure is not unwisely handled and we have believed that each step has a purpose. Many of our patients have received muscle relaxants either syncurine or succinyl choline. Syncurine is not potentiated by quinidine or procaine amide. It does not have any direct depressant effect on the myocardium as has been reported with succinyl choline. We have not had any problems with prolonged somnolence and all patients have awakened promptly following the procedure.

Conclusions

This study has encouraged us in the further use of electric countershock therapy and opened up a broad new horizon of therapy for supraventricular arrhythmias. Most of these people would have gone on through life with maintenance digitalis therapy, but now can enjoy the benefits of full myocardial activity. Some of these arrhythmias have persisted for as long as two years and can be successfully terminated by elective external electric countershock therapy. We suggest the use of digitalis, quinidine and anticoagulants in chronic arrhythmias. We also feel that the procedure should be an elective one to provide time for adequate coagulation effect. It is our firm opinion that a suitable area should be chosen for the conversion attempt. Despite the fact that relapses to previous arrhythmias did occur in 30 per cent of the patients, the assets of the procedure far outnumbered the liabilities.

Acknowledgment

We are deeply indebted to the Anesthesia Department of Butterworth Hospital for their splendid cooperation in these procedures and in the assistance given toward the preparation of this paper.

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Backs "Operation Hometown"

"Gentlemen, don't forget 'Operation Hometown.' This is an opportunity each of us has to give some small portion of our time and energies to preserve the best medical system in the world and the democratic American way.

"American medicine is a slumbering potent giant, intelligent, articulate, and independent. A giant that must awaken and stir before too many lilliputian ropes make its awakening ineffectual."

These are excerpts from an editorial by V. V. Bass, M.D., in the *Saginaw County Medical Society Bulletin*, September, 1963.

Treatment of Congestive Failure With Peritoneal Dialysis

Bernard Bercu, M.D.
John N. Heinz, M.D.
Robert Anderson, M.D.
Eloise, Michigan

THE USE of peritoneal dialysis for the treatment of acute renal failure or for some types of drug poisoning has become a familiar and acceptable treatment.[7] However, the use of this form of dialysis for the treatment of anasarca associated with heart failure has not enjoyed such wide acceptance. This may be due in part to the large number of diuretic agents available for the treatment of edema, and to the frequently chronic nature of the patient's basic condition.

It has been amply shown in the past that large amounts of fluid can be removed from the body by peritoneal dialysis, when glucose concentrations of 2.5 to 5 per cent are used in the dialyzing fluid.[1] In the authors' experience, fluid removal can be accomplished more readily by peritoneal dialysis than by hemodialysis. Our use of peritoneal dialysis for the treatment of severe congestive heart failure with edema was initially started only after prolonged periods of diuretic therapy and hospitalization. After it was demonstrated that patients responded readily to dialysis and that their clinical state could be rapidly improved, this form of therapy has been employed more frequently. This is not to imply that peritoneal dialysis should be used for congestive failure that responds to the usual forms of medical management. Rather, this paper demonstrates the beneficial use of peritoneal dialysis for the individual who can be diuresed with difficulty or not at all.

Method

Patients with cardiac failure were selected on the basis of marked fluid retention which did not respond to conventional therapy. Some had been dialyzed early in the course of their therapy because the usual treatment of edema was judged inadequate to meet the needs of their critical physical condition.

Equipment used included a paracentesis tray and a disposable peritoneal dialysis catheter.* The skin was prepared with tincture of Zephiran, and sterile drapes were applied. Procaine or Xylocaine was used as a local anesthetic prior to insertion of the paracentesis trocar. This trocar has been made just large enough for the dialysis catheter to pass through it.† The usual site selected was located in the midline, one-third of the distance from the umbilicus to the pubis.

The dialysate consisted of "stock" hospital solutions made up so that all ions were approximately isotonic with the exception of glucose which was varied from 2.5 to 5 per cent depending upon the amount of fluid to be removed. An important factor was the individual response of each patient. Some required higher glucose concentrations in the dialysis fluid than others to obtain an equal volume in the dialysate. Typical solutions were as follows: One liter of normal saline, one-half liter of 5 per cent Dextrose in normal saline, one-half liter of 5 per cent Dextrose in water, 75 mg of sodium lactate, 10 cc of 10 per cent calcium gluconate and 8 meq. of KCl.

The cycling time was two hours. The first hour was used to run fluids into and remain in the abdomen and the second hour was used for dependent drainage.

The usual amount of fluid removed per cycle varied from 300-1000 ml with an average of approximately 500 ml. Some patients tolerated removal of fluids at a more rapid rate but their response had to be observed carefully. It is important to weigh each patient prior to dialysis and once daily thereafter. Any discrepancies in fluid balance calculations could be resolved by noting the change in body weight.

From the Department of Medicine, Wayne County General Hospital, Eloise, Michigan.

This work was done under a grant from the Michigan Heart Association.

*Baxter Laboratories, Morton Grove, Illinois.
†Sarns, Inc., Ann Arbor, Michigan.

Dialysis cycling was continued in most cases for twenty-four to forty-eight hours. Serum electrolyte studies were obtained daily.

Case Reports

Case 1.—A 54-year-old male Caucasian was first admitted to Wayne County General Hospital on April 2, 1962 for shortness of breath and chest pain of one month's duration. He had been receiving digitalis and diuretics from a private physician. Despite this treatment, he became progressively more short of breath and developed anasarca.

Three years prior to admission, the patient had gangrene of the right great toe. An additional area of gangrene developed in the same area one month prior to admission.

Physical examination on admission showed a well-developed and obese, male Caucasian who was moderately dyspneic. His oral temperature was 98.6 F.; pulse rate was 100/minute and regular; respirations were 36/minute; and the blood pressure was 160/84 mm. Hg. His weight was 271 pounds. Examination of head, eyes, ears, nose, and throat was unremarkable except for bilateral iridectomy scars. The neck veins were distended. There were moist, fine rales in the left posterior lung base. There was dullness over the left lower lung and breath sounds were decreased over this area. Examination of the heart revealed the point of maximal impulse in the left fifth interspace in the midaxillary line. There was a grade three systolic apical murmur of a regurgitant type which radiated to the axilla. There was an accompanying thrill. There was marked edema with erythema of the abdominal wall. The liver was palpable 8 cm. below the right costal margin. Shifting dullness was noted on percussion of the abdomen. There was marked scrotal and penile edema. 4+ pitting edema and marked erythema of both lower extremities was noted. There was gangrenous change of the right great toe.

Laboratory studies revealed hemoglobin of 12.4 g/100 ml.; venous hematocrit reading of 42%; WBC count of 7200/mm^3; and a normal urinalysis. A 24-hour urine volume was 990 ml.

The blood urea nitrogen was 20 mg/100 ml.; the fasting blood sugar was 103 mg/100 ml.; the serum sodium was 161 meq/liter; the potassium was 4.9 meq/liter, the chloride was 90 meq/liter; carbon dioxide combining power was 34 meq/liter and the serum glutamic oxaloacetic transaminase was 25 units. The serum bilirubin was 2.3 mg/100 ml.; the total serum protein was 7.0 Gm/100 ml. with 3.6 Gm/100 ml. albumin. The electrocardiogram showed first-degree atrioventricular block, wide, notched P waves and inverted T waves in V5 and V6.

Roentgenogram of the chest on admission revealed an enlarged cardiac silhouette, pulmonary congestion and possible pneumonitis of both lung bases.

The patient was treated with a 400 mg. low-salt diet, digitalis leaf 0.1 Gm./day, Mercuhydrin in 2 ml. doses, chlorthiazide 500 mg. two to three times a day, K-triplex and bed rest. The patient left the hospital against advice on May 21, 1962 after losing 25 pounds.

Eighteen days after discharge, the patient returned to this hospital stating that his symptoms had become worse. He had gained 10 pounds; his general condition had deteriorated and he appeared moribund. Because of our increasing experience with peritoneal dialysis, it was decided to remove the patient's excess fluid by this procedure. The fluid used was isotonic except for the addition of 2.5% to 5% glucose. Two-hour cycles were continued over a total of 18 hours. During this time, approximately 10 liters of fluid were removed and the patient began to diurese spontaneously. This diuresis continued for 2 weeks at which time the patient's weight had fallen to 170 pounds. This represented a loss of 70 pounds. Improvement was noted at the end of the first dialysis cycle. This improvement was progressive and the patient was discharged August 1, 1962. The patient was subjected to open-heart surgery October 4, 1962 where a clinical diagnosis of ruptured chorda tendina was confirmed.

Case 2.—A seventy-five-year-old white woman was admitted to Wayne County General Hospital on March 16, 1963 with a diagnosis of massive anasarca, jaundice and atrial fibrillation. Onset of symptoms occurred four years prior to admission at which time she had severe crushing substernal pain. Three months prior to admission she became anorexic, short of breath, had paroxysmal nocturnal dyspnea and dyspnea on exertion. She also developed progressive swelling of her ankles and massive swelling of her abdomen. This increased in severity until the time of admission. Physical examination on admission revealed an elderly white female with massive edema of all extremities, the back, and abdominal wall. Her blood pressure was 100/75 mm mercury, the pulse 96/minute and irregular and the respirations were 20/minute. Her sclerae were slightly icteric. There were distended neck veins. Rales were heard in both lung fields. No murmurs were audible. There was some ascites. The liver edge was palpable three centimeters below the right costal margin. A firm tender mass was palpated about two centimeters above the umbilicus extending from the rigid upper quadrant. Laboratory studies revealed Hb 13.5 gms, WBC 8,050, Urinalysis, negative, Kline and Kahn, negative, BUN, 40, Bilirubin 5.2 mg/100 ml., Creatinine 1.6 mg/100 ml., Glucose 118, Cl 86, Co2 29, K 4.2, Na 135, SGOT 29, Alkaline phosphatase 6.7, Prothrombin time (control 12.5 seconds) 15.5 seconds 56%, Total protein 7.0, Albumin 3.0, Globulin 4.0, Cephalin floculation 3 plus. The EKG showed an anteroseptal infarction of unknown age. X-rays revealed cardiomegaly and pulmonary congestion. There was mild liver enlargement.

The patient was treated with a low-salt diet, digitalis leaf, hydrodiuril, Mercuhydrin, K-triplex, Aldactone and bed rest. Under this regimen, her weight fell from 170 pounds to 145 pounds in six weeks; however, significant edema remained. Diuresis did not progress at that point and the patient's general condition appeared to be deteriorating. It was considered imperative to correct her congestive failure rapidly. Dialysis was carried out over 36 hours, and the patient's weight was reduced 13 pounds. She continued to diurese over the next two weeks so that her weight decreased to 111 pounds. She was dialyzed again, a few weeks later after she developed an idioventricular rhythm secondary to hyperkalemia. This converted to a sinus rhythm within several dialysis cycles and 4 pounds of edema fluid were removed. Following dialysis, the patient continued to improve, and on June 3, she was successfully subjected to laparotomy.

Discussion

The suggestion that fluid could be removed from the body by dialysis was proposed approximately 15 years ago in 1948.[1,2] Isolated case reports have appeared in the literature since then and have continued to confirm the value of this form of treatment for patients with severe congestive heart failure.[3-6] In spite of the value of peritoneal dialysis for patients in heart failure with edema and its undoubted application in many medical centers in this country, little has appeared in the recent English literature to indicate the techniques employed and the indications for its use.

The cases presented demonstrate how peritoneal dialysis can be used to remove large amounts of retained fluid even when intensive efforts at securing diuresis by other means have failed. This has been true for patients who were thought to be moribund when dialysis was started. Other patients have been able to leave the hospital shortly after dialysis was applied when months of hospitalization and conventional treatment were unsuccessful. Peritoneal dialysis can be used to significantly shorten the hospital stay of those patients who have marked anasarca and are responding slowly to the usual therapy.

Since many patients with cardiac lesions can be treated by open-heart surgery, peritoneal dialysis can be used to salvage those who would otherwise be regarded as being unsatisfactory operative risks. Our experience also suggests that infants with congenital heart disease in intractable failure being prepared for surgery might benefit from this form of dialysis.

Patients with congestive failure and edema have frequently continued to diurese following removal of some fluid by peritoneal dialysis so that previous therapy to which they were refractory could be applied successfully. This suggests the need for more experience with the use of dialysis for patients with persistent chronic congestive heart failure who are not responding to conventional therapy.

Many patients with severe congestive heart failure develop electrolyte abnormalities during strenuous attempts at diuresis. Hyponatremia due to excess water retention, hypochloremic alkalosis, and prerenal azotemia are all easily corrected during peritoneal dialysis, since the extracellular fluid equilibrates with the isotonic peritoneal fluid, and electrolytes are added to or removed from the extracellular fluid according to their concentration. At the same time, water is removed from the body, and renal function is supplemented. When it is apparent that a patient with severe serum electrolyte abnormalities may not survive the period required to correct these abnormalities, peritoneal dialysis can be used as a simple expedient to bring about the desired result.

Some clinicians may be hesitant to utilize peritoneal dialysis because the procedure itself seems somewhat formidable. This has not been the experience of the authors, especially if the patient has not had previous abdominal surgery where concern over adhesions between the intestinal tract and abdominal wall can be eliminated. When a patient has been operated upon previously, it is important to insert the peritoneal trocar and catheter in an area away from the abdominal scar.

Summary

These cases are presented to demonstrate that peritoneal dialysis can be used successfully to treat intractable congestive heart failure.

It is suggested that this method be used to shorten the hospital stay of patients with severe congestive heart failure not quickly responding to conventional therapy. It may also be used in preparing adults and infants in intractable heart failure for cardiac surgery. Peritoneal dialysis can relieve persistent severe congestive failure since some of our patients have continued to diurese spontaneously after part of their fluid overload was removed by this technique.

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MICHIGAN DEPARTMENT OF HEALTH
ALBERT E. HEUSTIS M.D., State Health Commissioner

Reorganization of State Health Services

In the near future, decisions will be made regarding reorganization of state government as required by the new constitution. Of particular significance to the medical, dental, nursing, and allied paramedical professions, will be the manner in which state health services are regrouped. Ideally, this will be done in such a way as to allow the state to deliver the greatest amount of health service to the greatest number of people at the lowest possible cost.

Earlier this year, at the request of the Governor, the state health department submitted a proposal which would replace the existing hodge-podge of state health services with a single agency responsible and accountable for the delivery of health services to the people. Copies of this recommendation were shared with some 300 medical and lay advisors to the department asking for critical review. In addition, the proposal was reviewed in detail with the presidents and executive secretaries of 19 major voluntary health agencies at a meeting held in June. In general, there was a concensus that the proposal was based on valid grounds, marked a good beginning, and should be further explored and developed.

Essentially, the proposed new health agency would not add anything new in the way of state health services but would instead bring health functions together for efficiency, reasonableness, and some kind of uniformity. The new agency would combine the existing functions of the state health department, mental health department, Crippled Children Commission, Board of Alcoholism, Water Resources Commission, and the Construction Safety Commission. In addition, milk and food sanitation work related to human health of the Department of Agriculture and the Liquor Control Commission, along with industrial safety programs of the Labor Department, would be integrated with ongoing state and local health programs in these areas, thus eliminating the present duplication of effort along these lines. And finally, the proposed new agency would combine all standard and rate setting for medical and hospital care purchased by the state, including that currently paid for by the Welfare Department, Veterans Trust Fund, Board of Alcoholism, and the Crippled Children Commission. Guiding the standard and rate setting would be a Council on Professional Care composed primarily of physicians.

All current statutory advisory boards to the various state health agencies would be retained with their current make-up and duties, except that they would become advisory to the head of the new department who would be appointed by the Governor with the advice and consent of the Senate. The proposal explicitly recommends that this person not be anyone currently heading up any of the present state health agencies.

In developing the proposal, the department used the following guidelines for the new agency.

1. It does not include any expansion of current governmental responsibilities for health services.
2. It does bring existing services together for more effective and economical services.
3. It retains citizen participation and advice, including that of practicing physicians, on numerous advisory councils.
4. It focuses responsibility and accountability for public funds.
5. It coordinates, rather than further fragmenting, existing local governmental health service.
6. It anticipates an agency head outside of the current framework of public health services in Michigan.

A detailed description of the reorganization proposal has been sent to every physician in the state, as printed in the October issue of the department's regular bulletin "Michigan's Health." It is our hope that this proposal along with all other proposals that have been, or will be, made will be given careful study by all concerned.

Under the new constitution, it is clear that some mergers will be required. Certainly, all health-related professions should be able to get together and agree on a reorganization plan that will be more than a patchwork and really will do a better job for the people of Michigan. The interest, good will, and leadership of the practicing physicians of this state can be an important element in achieving this goal.

Michigan Pride

Michigan medicine is rightfully proud of the contribution its members make in teaching, patient care, and research. The Michigan Heart Association is one of the finest organizations in the nation in all three of these areas. This issue of THE JOURNAL clearly demonstrated some of the accomplishments in which the Michigan Heart Association has had a major role.

Perhaps not so well known, but of great importance, is another area of interest for this organization known as the Michigan Heart Association Dean's Fund.

The Dean's Fund of the Michigan Heart Association has as its objective the retention of desirable individuals in the field of academic medicine who otherwise might be lost, due to lack of adequate budgetary support or an available vacant position. Its awards are available to Doctors of Medicine who have completed their residencies. Nominees should have usual responsibilities in teaching and should engage as well in some type of research in the cardiovascular field. This form of support is unique in that no strings whatever are attached in the time allotted between research as opposed to teaching. The individuals must be on the faculty of a medical school and should be full-time with no private practice or fee for service activity.

This voluntary level of support has, since its inception in 1958, supported 19 physicians at the University of Michigan and 15 at Wayne State University. The size of the support is notable, with the University of Michigan, in that period of time, receiving $117,004 and Wayne State University receiving $136,800.

For the young men who have benefited from this support, for the doctors who have been given new knowledge to work with, and for the patients' benefit, which is the final reason for the entire effort, we thank and congratulate the Michigan Heart Association.

C. J. TUPPER, M.D., *Editor*

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Chipping Away at the Private Practice of Medicine

By Henry C. Bryant, M.D.
Ann Arbor

The progress of laboratory medicine has contributed much in assisting the attending physician in the diagnosis and treatment of disease.

During the early years all procedures in hematology, biochemistry and bacteriology were performed by licensed or graduate physicians. As the demand increased, technicians, registered medical technologists and Ph.D. scientists were utilized in performing the techniques of various analyses in the clinical laboratory. With the growth of knowledge concerning the application of these data to patient care, the physician practitioner of laboratory medicine devoted more of his time to the evaluation of this information, acting as a consultant to the attending physician, and supervising and maintaining high quality techniques in the clinical laboratory through the initiation of more refined and newer techniques as well as quality control programs.

Hiatuses in our state statutes regarding medical practice, and the concentration of organized medicine on other important issues of the time, allowed technicians with varying qualities of training, scientists trained in only one field and without a medical background, and other laymen to open and operate clinical laboratories. The situation has persisted on a growing scale to this day. As long ago as 1928 the Council on Medical Education and Hospitals of the American Medical Association made the following statement in their report:

> ". . . during recent years laboratory work has fallen largely into the hands of lay technicians and has become the toy of persons who have a purely commercial point of view and little training for the work. . . . In order to secure the best analyses for the benefit of their patients, as well as to conserve the interest of the medical profession, physicians should refuse to have their work done in laboratories conducted under the direction of non-medical persons."

In 1939, and on several occasions since that date, the American Medical Association has repeatedly declared that the practice of pathology is the practice of medicine in the same sense as other designated fields of medicine. The Michigan State Medical Society over the years has taken the same stand.

Non-physician scientists, non-registered laboratory technicians and poorly trained lay laboratory directors through their own organizations have campaigned for acceptance by organized medicine of their right to practice laboratory medicine independent of medical control or supervision. These groups have also been responsible for the introduction of licensure bills in state legislatures.

The purpose of these bills is for government regulation of the practice of laboratory medicine, as well as an attempt to gain through legislation a professional status in the practice of medicine that these individuals do not possess by virtue of training or education. Such bills have already been passed by at least eight states. There has been discussion of the possibility of introducing such a bill in Michigan. In Washington, D. C., and the states of Iowa, Minnesota, Wisconsin, South Carolina and more recently Texas, the practice of pathology has been legally declared the practice of medicine. As a result, there is no lay laboratory problem in these states.

The poor quality of work performed in many of these lay operated laboratories was described several years ago in exposés in the *New York Times* and in *Time* magazine. The medical hazard to the welfare of the patient because of poor quality work and fabricated results cannot be over-emphasized. The flooding of physicians' mail with advertisements, cut-rate fee schedules and contract offers represent a standard mode of operation. The utilization of such facilities at such fees also provides the temptation for fee splitting with the lay laboratory director.

Physicians should rightfully be concerned about the intrusion of these individuals into this field of medical practice. It would seem

that other than by concerted action of the medical profession, lay operated laboratories will be with us until the state of Michigan legally proclaims laboratory medicine as the practice of medicine and requires medical licensure in order to practice in this field. This legislation can only be accomplished by responsible citizenry under the leadership of the medical profession.

Crash or Coronary

By G. Donald Albers, M.D.
Grand Rapids

Arterial accidents must be prevented, whether in human coronaries or on inhuman highways. How many useful and productive lives must be offered every few minutes as human sacrifices on the altar of ignorance and carelessness?

Complacency clouds our consciences as we shirk our responsibilities. As physicians we must step forward, study the problems, examine the records, advise and educate the public. Cardiac factors are the major reasons for rejection of drivers on their medical examinations.

Medical aspects of automobile accident prevention demand our immediate attention. When over 100 Americans are killed every day on our highways, we are confronted with a serious epidemic. Why do we sit idly by and wait for more misery and violence to ensue?

Commonplace casualties are carelessly documented, data is haphazardly tabulated, and superficially investigated. No unformity of examination of fatal crashes exist at present. Comparison of one area with another or nationally cannot be done scientifically. Simple mechanical defects on all vehicles must be checked periodically. Analysis of crash causes must also be standardized. We blindly permit unfit, ill-kept, and poorly driven automobiles to menace our thoroughfares.

Is the epitaph of our atomic age going to be "Planned Obsolescence"? Must we wait for a vital cog to break before we act? Even with quality control we must anticipate mechanical weakness and be prepared.

Now is the time to be firm and decide who is really qualified to drive. Periodic medical examinations of all drivers are necessary. Simple, quick efficiency tests must be used. Limited licenses in regard to driving hours, speed and roads, are needed to classify beginners, probationers, and the aged. Renewal of licenses should vary with the age and ability of the driver. Financial responsibility and liability insurance will have to be guaranteed.

The problem of the "drinking driver" requires unbiased analysis. We need proper screening for medicated drivers, whether tranquillized, narcotized or sedated. Emotionally disturbed and distracted persons cause many accidents. Defensive driving instead of offensive tactics should be employed. Changing travel habits with long monotonous toll-roads tax the tired driver as well as the diabetic or hypoglycemic individual.

Who should promote the safety features of the "Survival-cars"? Many worthwhile features, such as, shoulder harnesses; head-rests; roll-bars; and efficient brakes; are available now. Learn how to drive and stay alive. Help to eradicate the "Epidemic Car-crash" by proper education and legislation.

Thank You!

This number of THE JOURNAL is devoted to Heart articles. Appreciation is sincerely expressed for the cooperation of John C. Bielawski, M.D., Detroit, Medical Director for the Michigan Heart Association.

Medical students, interns and residents being aided by loans guaranteed by the AMA-ERF student loan program are in training in nearly every medical school and in 400 hospitals in almost every state in the Union. One in three comes from a family in which the father is retired, disabled or deceased.

MSMS Centennial Series

MSMS Faces World War I, Other Pressures And Problems during 1915-1929 Period

This is the third article in the MSMS Centennial Series briefly tracing the period of MSMS History from 1915 to 1929. The first article in the September Journal covered the first 50 years, and the article in the October Journal by Alfred H. Whittaker, M.D., Detroit, was about William Beaumont, M.D. A series of monthly articles, beginning in the December Journal, by MSMS Historian William J. Stapleton, Jr., M.D., Detroit, will bring the history up to the MSMS Centennial, which will be observed officially at the 1965 Annual Session in Detroit.

This article was written by Herbert A. Auer, Managing Editor of the Journal MSMS.

1915-1920

A. W. Hornbogen, M.D., of Marquette, served as president during 1915-1916. At the 1916 Annual Meeting, the House of Delegates unanimously took action "to go on record as recommending universal military training." The Delegates also heard reports about a state-wide tuberculosis survey, "the ever-increasing prevalence of syphilis and gonnorrhea in Michigan," the rising cost of printing the MSMS Journal, and other matters.

President for 1916-1917 and again for 1917-1918 was Andrew P. Biddle, M.D., of Detroit, who formerly had served as MSMS secretary and Journal editor. The War was of major concern and Doctor Biddle wrote in the Journal, "The medical profession has never failed in a national crisis and it will not fail in this. The keynote of its creed is service, service to its government, service to its people, service to humanity."



Andrew P. Biddle, M.D.

A special meeting of the Society was held in May, 1917 when the members voted an assessment of $5 per member "to create a patriotic fund to be used in assisting the families who might be in need on account of our members' admission to the Medical Officers' Reserve Corps."

At the annual meeting in 1918, Doctor Biddle in his President's Address recognized the plight of the county and state medical societies during wartime. He said, "The work of these societies should be kept as active as possible in the interest of medical organization. Those at home should make increasing efforts to maintain them in their present state of efficiency by frequent attendance and willing cooperation with the officers in perfecting the programs."

President Arthur M. Hume, M.D., Owosso, in his Address in 1919 commented on the end of the war and pointed out that "adjustments will come but most of them will come slowly, and conditions—economic, social and even financial—will be changed. We shall never readjust to conform to the older but there will ultimately be worked out a new economic and sociologic life and we must live that life or cease to live at all." He urged the delegates "to go home, get the boys together and have a real live county society meeting."

Referring to the spread of governmental programs in the care of the mentally ill and the epileptic and "the growth of state medicine in inspection," etc., C. H. Baker, M.D., Bay City, MSMS President for 1919-1920, sounded a challenge in his Address. He said, "The medical profession must unite more closely and be alert and watchful when medical legislation is proposed to see that its interests are not sacrificed to the commercial competitive idea which would treat skilled services as in the same class as cement and gravel to be bought from the lowest bidder." He added: "Medical service is about the only thing which the public has gotten free." He then went on to advise the doctors, while helping the unfortunate, to be "watchful of his own interests."

1921-1925

Timely comments about compulsory health insurance schemes were made at the 1921 Annual Meeting by President Angus McLean, M.D., Detroit, who led

the Society in 1920-1921. He declared, "Should compulsory health insurance be put in force, we would probably be in the same condition as those countries that have it, namely, Great Britain, Austria and Germany. . . . Let us have a committee from our own Society that will take this matter up and place it in a dignified form before the legislature."

An awareness to public relations problems was expressed by William J. Kay, M.D., Lapeer, President for 1921-1922, in his Address. Doctor Kay declared, "Our relationships as a group to other groups and to the whole body politics gives rise to differences, friction and criticism because of regulations which we think restrict our freedom of action and hampers our efforts for the common good. We are the autocrats of the sick room. We are used to saying, this is the proper course and it must be followed, "and we are obeyed, but we cannot carry this same autocratic spirit into the relationships of our group to the public."

The problems of relationships between the doctor and other elements (such as the State Department of Health, the medical colleges and other state organizations) had demanded considerable attention for several years, and William T. Dodge, M.D., Big Rapids, MSMS President for 1922-1923, declared in his Address, "I wish to impress upon you the necessity of considering the various problems of relationships." He advocated MSMS study committees of a permanent nature, with staggering terms for the committee members.

During 1923-1924, The MSMS Council held the first Conference for County Medical Society Secretaries. The Annual Meeting in 1929 heard a President's Address about the history of the State Board of Registration in Medicine by President Guy L. Connor, M.D., Detroit.

Changing trends in MSMS were noted in the President's Address given by C. C. Clancy, M.D., Port Huron, 1924-1925, who said: "Organizational problems of today are not those of even a decade ago. They are vastly more complicated, more numerous, more urgent and apparently more important in their effect upon the present status of medicine. It is no longer sufficient to meet and discuss questions of science only, there are many other matters pertaining to ethical, social and business principles to be considered and wisely disposed of, if the profession of medicine is to hold a commanding position in the present scheme of affairs."

A MSMS program of postgraduate clinical conferences was started during Doctor Clancy's administration.

A highlight during 1925 was the dedication of the University Hospital at Ann Arbor, November 19, 1925.

1926-1929

"The demand of the public for hospital service has been so great that development can hardly keep pace," declared C. G. Darling, M.D., MSMS President for 1925-1926, in his Address. He reported that "already there are 170 hospitals in Michigan with a total of 14,000 beds." He observed also that "the public had demanded a better standard for hospitals."

A proposed amendment to the Constitution "That the secretary-editor shall be elected by the House of Delegates" was defeated, and The Council was permitted to continue this appointment.

MSMS membership that year topped 3,000 with 3,013 on the rolls as of January 1, 1926.

J. B. Jackson, M.D., Kalamazoo, who served as president in 1926-1927, gave a review of Michigan medical practice laws in his President's Address. He commented that "in our present law there is inadequate provision for enforcement." He declared, "My contention is that enforcement of a medical practice law cannot be done through county prosecuting attorney." Doctor Jackson reported to the MSMS House of Delegates that the legislature that year had failed to pass a bill to establish a school of osteopathy in Michigan.

"Contributions of Medicine to Modern Civilization" were reviewed by H. E. Randall, M.D., Flint, 1927-1928 President, in his Address to the House of Delegates in 1928. He discussed progress in diagnostic methods, the valuable assistance from chemists and pharmacologists, the reduction in deaths from tuberculosis, etc. The action of the delegates included the appointment of a committee to confer with the Crippled Children Commission in Michigan "in order that a harmonious agreement and understanding may result from the cooperation of these two groups."

In his President's Address in 1929, Louis J. Hirschman, M.D., Detroit, President for 1928-1929, evaluated the legislative efforts of "cultists, irregular practitioners and enemies of scientific medicine to open the doors to the practice of the healing arts to the incompetent, the unprepared, the ignorant and the malicious." (Governor Green that year had vetoed some health bills that MSMS feared were "vicious and dangerous.") Doctor Hirschman commented also about the rapidly growing field of industrial medicine, the urban movement of doctors away from rural areas and the importance of MSMS-sponsored postgraduate conferences.

Almost through this 1915-1929 period of MSMS history, F. C. Warnshuis, M.D., of Grand Rapids, served as secretary of MSMS. He was elected in 1913 and continued in office for 16 years until 1929. Doctor Warnshuis was the first secretary in many years to

provide such continuity—the all-time service record for component secretaries was set by George E. Ranny, M.D., of Lansing, who was in office 20 years from 1866 to 1886.

The last MSMS Charter Member, Henry Bishop Landon, M.D., died January 15, 1929.

PAST PRESIDENTS

1915-1929

1915—Alfred W. Hornbogen, Marquette
1916-17—Andrew P. Biddle, Detroit
1918—Arthur M. Hume, Owosso
1919—Charles H. Baker, Bay City
1920—Angus McLean, Detroit
1921—William J. Kay, Lapeer
1922—William T. Dodge, Big Rapids
1923—Guy L. Connor, Detroit
1924—Charles C. Clancy, Port Huron
1925—Cyrenus G. Darling, Ann Arbor
1926—John B. Jackson, Kalamazoo
1927—Herbert E. Randall, Flint
1928—Louis J. Hirschman, Detroit
1929—Jacob D. Brook, Grandville



Honored By MSEA

The Medical Society Executives Association honored Wm. J. Burns, MSMS executive director, at its annual meeting in Chicago on August 20, 1963. Making the presentation of a book of 150 letters of appreciation from MSEA members is C. Lincoln Williston, Texas State Medical Society executive director, president of MSEA.

Wayne State Names New Dean of Medicine

The Wayne State University Board of Governors has named Ernest D. Gardner, M.D., former associate dean of the College of Medicine, as Dean of the College.

Dr. Gardner succeeds Gordon Scott, Ph.D., Vice President for Medical College development, who continued to carry the title of dean when he became Vice President in 1961. Dr. Scott, medical dean since 1950, is relinquishing the post to concentrate on Medical Center development.

Joining WSU as an assistant professor of anatomy in May, 1945, Dr. Gardner was promoted to professor and chairman of anatomy in July, 1950, and to the associate deanship 11 years later.

How About It?

A challenge was leveled at the 1963 House of Delegates by Mrs. Ross V. Taylor, of Jackson, in her Annual Report of the President of the Woman's Auxiliary.

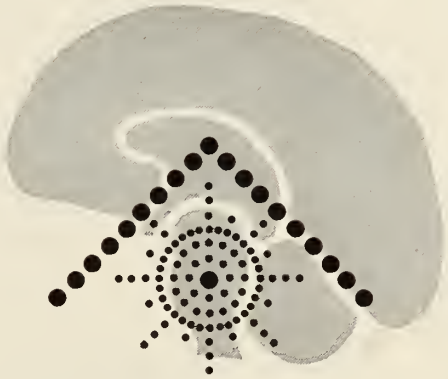
She said the following, aiming her comments at every MSMS member: "You, most of you, have acknowledged us as your allies. I wonder if you are fully aware of your 'woman-power potential.' Are you in your counties taking time to give your wives in their auxiliaries the guidance they need?

"What we accomplish for American Medicine, for you—and this is our sole reason for existing as an auxiliary—can be done only by the county members who are your wives.

"Are your auxiliaries working on projects that you, their medical societies, endorse? Unless auxiliary members know what their medical societies want them to do, and what they do not want them to do, they are not in a position to make a maximum contribution to the overall effort."

Mental Health Training

Training programs in the sciences and allied fields conducted at Michigan Department of Mental Health training programs within the Department agencies cover two major areas: (1) inservice training to serve those performing staff functions within a hospital or clinic and whose primary need is a continued educational program to improve performance of their assigned tasks; and (2) supervised clinical experience for graduate training of personnel in mental health facilities currently have 1,752 persons in training. The professions of psychiatry, nursing, social work and psychology.



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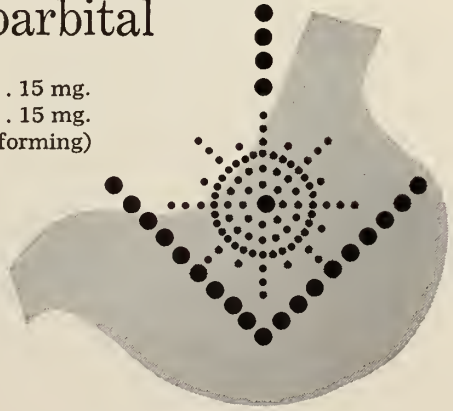
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RORER WILLIAM H. RORER, INC., FORT WASHINGTON, PA.

Dan Reed, Farm Bureau, Elected to MMS Board

Five physicians and seven public members were elected to the Board of Directors of Michigan Medical Service (Blue Shield) at the 23rd Annual Meeting in Grand Rapids. Nine of the twelve were re-elected to the Board.

Physicians re-elected to three-year terms were: Sidney Adler, M.D., Detroit; Howard G. Benjamin, M.D., Grand Rapids; and Ernest P. Griffin, Jr., M.D., Flint. James B. Blodgett, M.D., Detroit, a former member of the Board, was also elected to a three-year term.

Dan E. Reed, of Lansing, associate legislative counsel for the Michigan Farm Bureau, is a newcomer to the Board, representing the public. Other public representatives re-elected were: Ferry B. Allen, vice president, secretary and treasurer, Michigan Bell Telephone Co., Detroit; Irving J. Bluestone, administrative assistant to UAW president Walter P. Reuther; Malcolm L. Denise, vice president-labor relations, Ford Motor Company, and Harry S. Rudy, vice president, The Detroit Bank and Trust Company.

For the first time since Blue Shield's founding, a Doctor of Osteopathy was elected to Board membership. He is Philip Adler, D.O., of Oak Park.

Re-elected to one-year terms as representatives of the Michigan Hospital Association were: Roger W. DeBusk, M.D., Director of Grace Hospital, Detroit, and Roger B. Nelson, M.D., Associate Director, University Hospital, Ann Arbor.

The members of the Corporation voted to change the bylaws to permit the membership of at least one Doctor of Osteopathy in the Board of Directors and also voted to reduce the number of physicians from two-thirds to three-fifths or, numerically, 21 doctors and 14 public members, including hospital representatives.

Doctor Adler was re-elected to a third term as president of Michigan Medical Service at the organizational meeting of the Board of Directors, October 9.

Also re-elected were: James M. Gillen, director, personnel research, General Motors Corporation, First Vice President; Donald N. Sweeny, Jr., M.D., of Detroit, Second Vice President; Harry S. Rudy, vice president, The Detroit Bank & Trust Company, Treasurer, and Allan K. Cameron, M.D., of Saginaw, Secretary.

Re-elected first assistant treasurer was Jay N. Mossman, director of Blue Shield's finance division. Arthur Clements, special assistant to the deputy executive director, was re-elected first assistant secretary of the Corporation.





Mrs. Richard A. Sutter, Vice President, Woman's Auxiliary to AMA, St. Louis, Missouri, left, assists in the installation of Mrs. R. J. Himmelberger, of Lansing, as the new President of the Woman's Auxiliary to the Michigan State Medical Society. Watching the ceremony are Mrs. Milton S. Weed, Detroit, the new President-Elect, and Mrs. Ross V. Taylor, Jackson, the Past-President.

Mrs. Himmelberger, President Of Woman's Auxiliary

Mrs. R. J. Himmelberger, Lansing, was installed as President of the Woman's Auxiliary to the Michigan State Medical Society at the Auxiliary annual meeting in Grand Rapids.

She succeeds Mrs. Ross V. Taylor of Jackson.

Mrs. Milton Weed, Grosse Pointe, was chosen as President-Elect.

Also elected were the following: First Vice President, Mrs. R. H. Reitzel, Mount Clemens; Second Vice President, Mrs. Henry Scovill, Ypsilanti; Financial Secretary, Mrs. K. E. Fellows, Grand Rapids; Corresponding Secretary, Mrs. C. J. Stringer, Lansing; Treasurer, Mrs. Jack Hoogerhyde, Grand Rapids; and to the Board of Directors—Mrs. Frank Prather, Milford; Mrs. Robert Brown, Battle Creek; Mrs. C. A. Schoff, Midland; Mrs. C. H. Clausen, Sault Ste. Marie.

Allergists Elect

Serving now as president of the Michigan Allergy Society for 1963-64 is Israel Wiener, M.D., of Detroit.

James A. McLean, M.D., Ann Arbor, is the president-elect.

Other officers include John H. Burger, M.D., Birmingham, and Norman W. Brey, M.D., Detroit.

Port Huron Doctor Leads Public Health Officers

Robert E. Rowe, M.D., Port Huron, is president of the Michigan Health Officers Association, succeeding E. J. Brenner, M.D., of Mt. Pleasant.

Elected at the annual meeting as President-Elect was E. S. Parmenter, M.D., of Alpena.

Serving with Doctor Rowe this year are Frank J. Condon, M.D., Royal Oak, as secretary, and Irwin Sweet, M.D., Gladwin, as treasurer.

Medical-Dental Ski Conference Program Set for February

The third annual Canadian-American Medical and Dental Ski Association will meet at the new Harbor Highlands Ski Resort near Harbor Springs, February 17, 18, 19. Fred Levit, M.D., Chicago, will speak on "Dermatologic Problems of the Mouth and Muccal Mucosa." Robert D. Larsen, M.D., Detroit, will speak on "Injuries of the Hand." William A. Lange, M.D., Detroit, will speak on "Basal Cell Carcinoma of the Face." Clare H. Grosenbaugh, M.D., Grand Rapids, will speak on a psychiatric subject.

Dean Robb of Detroit will present a medico-legal topic.

President of the Society is John Hall, M.D, of Sault Ste. Marie, Ontario. Secretary-Treasurer is T. J. Trapasso, M.D., of Sault Ste. Marie.



Mrs. Dorothy Brandis, left, of Lansing, is installed as the new President of the Michigan State Medical Assistants Society in Grand Rapids by Miss Esther Bartlett, Detroit.

Mrs. Brandis to Direct State Medical Assistants

Mrs. Dorothy Brandis, of Lansing, will direct the activities of the Michigan State Medical Assistants Society for 1963-64. She was installed at the recent Annual Meeting in Grand Rapids as President to succeed Miss Esther Bartlett.

The annual convention delegates elected Miss Phyllis Marquardt, of Kalamazoo, as President-Elect.

Other officers chosen were Mrs. Juanita Ferman, Jackson, Vice-President; Mrs. Elizabeth Attaway, Flint, Recording Secretary; Miss M. Marie Weatherwax, Ann Arbor, Treasurer, and Mrs. Betty Lou Willey, Port Huron, as Speaker of the House.

One of the highlights at the convention was the election of Alberta Warmbold, of Paw Paw, as "Medical Assistant of the Year." She is the fourth medical assistant to win this coveted honor.

(Turn to Page 1120)



Smooths out emotional peaks and valleys

'Meprospan'-400 brand of meprobamate contains 400 mg. in sustained-release form. One capsule smooths out the anxious patient's emotional peaks and valleys for 10 to 12 hours — and provides these other advantages:

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(Continued from Page 1118)

Grant Applications Due

Deadline to file applications for Grants-in-Aid for research projects dealing with cardiovascular and similar studies, is December 15, reminds John D. Littig, M.D., Kalamazoo, chairman of the Research Committee of the Michigan Heart Association. Last year the association approved 39 grants, whose costs ranging from $2,500 to a maximum of $10,000, totalled $263,492.

Application forms are now available from the Medical Director, 13100 Puritan, Detroit 27, Michigan.

Joins Mental Health Staff

Edward N. Hinko, M.D., director of Cleveland Psychiatric Institute and Hospital since 1955, has joined the Michigan Department of Mental Health as assistant director.

Dr. Hinko will head the division of Hospital Programs for the Mentally Ill and will be responsible for psychiatric care and treatment functions of the hospitals, professional training, and research activities.

This appointment is in line with Governor Romney's announced intention to strengthen Michigan's mental health programs.

Medical Technologist Honored

Miss Hazel Stoerck, of William Beaumont Hospital in Royal Oak, was recently named "Michigan Medical Technologist of the Year" at the combined conventions in Detroit of the Michigan and Ohio Societies of Medical Technologists.

Miss Stoerck, a University of Michigan graduate, is chief technologist and teaching supervisor at William Beaumont Hospital.

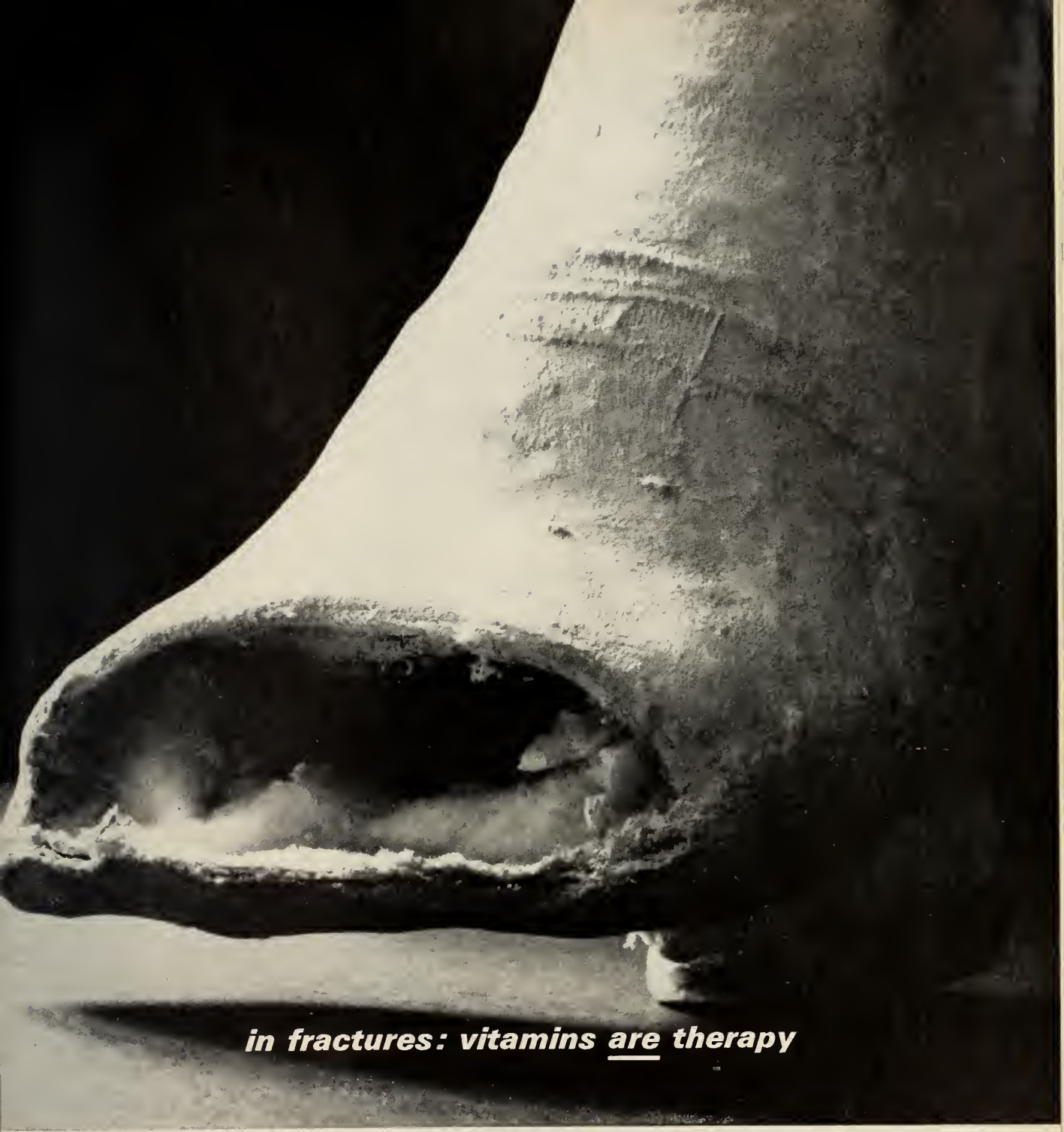
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*Warning—may be habit forming

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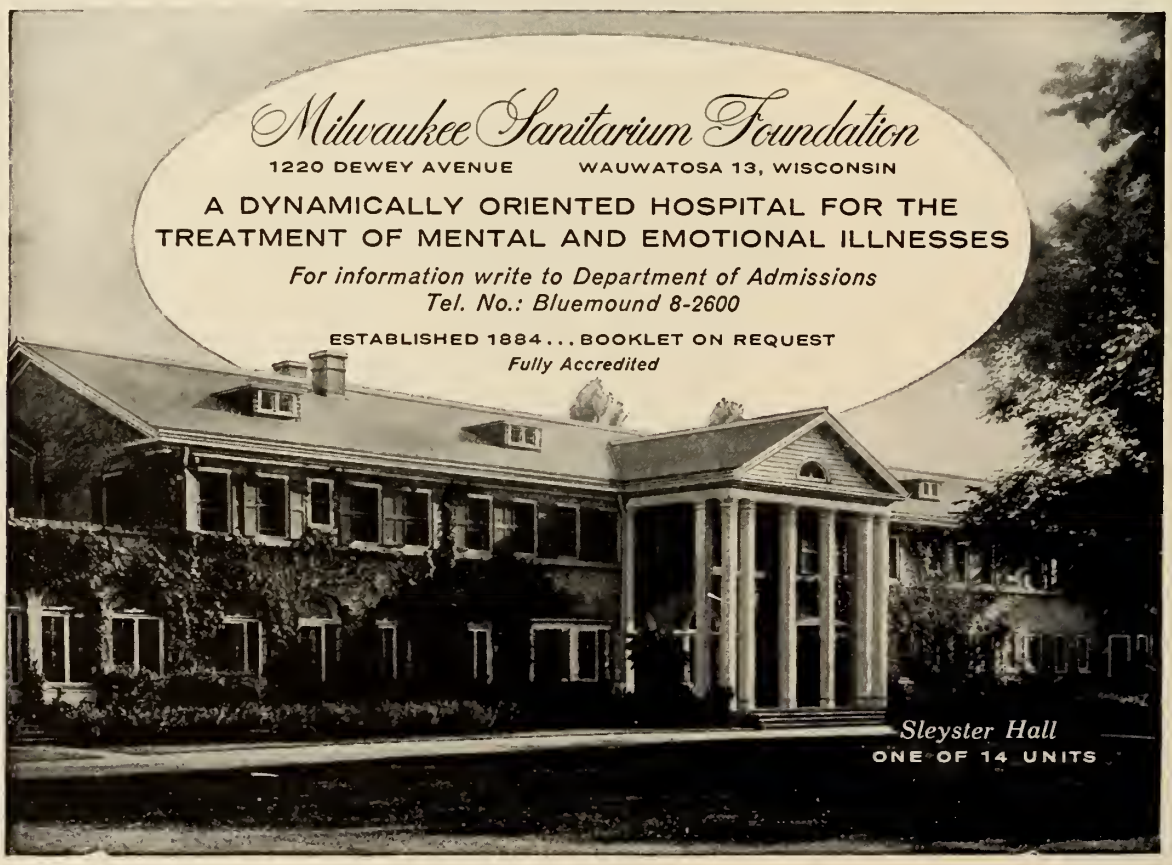
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Brief and to the Point

DONALD J. JAFFAR, M.D., Detroit, is the new president of the North Central Section of the American Urological Association. He is a member also of the executive committee of the American Urological Association and chairman of the National Committee on Graduate Instruction.

SPEAKERS—Two MSMS members spoke to the Seventh Annual meeting of the Michigan Association for Emotionally Disturbed Children. Hunter H. Comley, M.D., Detroit, and Stuart M. Finch, M.D., Ann Arbor, were on the program at the Detroit event.

BACK FROM AFRICA—Grover Fattic, M.D., is back in Niles after heading a mission hospital in Ruanda, Africa, for several months.

TALKS TO NURSES—The graduation services for the first class of Practical Nurses at the Benton Harbor Community College featured an address by Richard E. Lininger, M.D., St. Joseph.

RECEIVE GRANTS—Two Grosse Pointe doctors, James H. Graves, M.D., and Kenneth Pitts, M.D., have received grants through Wayne State University from the Michigan Board of Alcoholism for research and training programs.

ON NATIONAL PROGRAM—Several MSMS members were on the program for the 12th Annual Conference of the U. S. Civil Defense Council in Rochester, N. Y., October 20-25. Participants included Charles P. Anderson, M.D., Detroit; Douglas H. Fryer, M.D., Lansing; Albert E. Heustis, M.D., Lansing; Max L. Lichter, M.D., Melvindale; and Carl J. Sprunk, M.D., Detroit.

SPEAKER—Robert G. Heneveld, M.D., Muskegon, appeared on the program for the 32nd annual convention of the Michigan Association for Better Hearing, held in Muskegon.

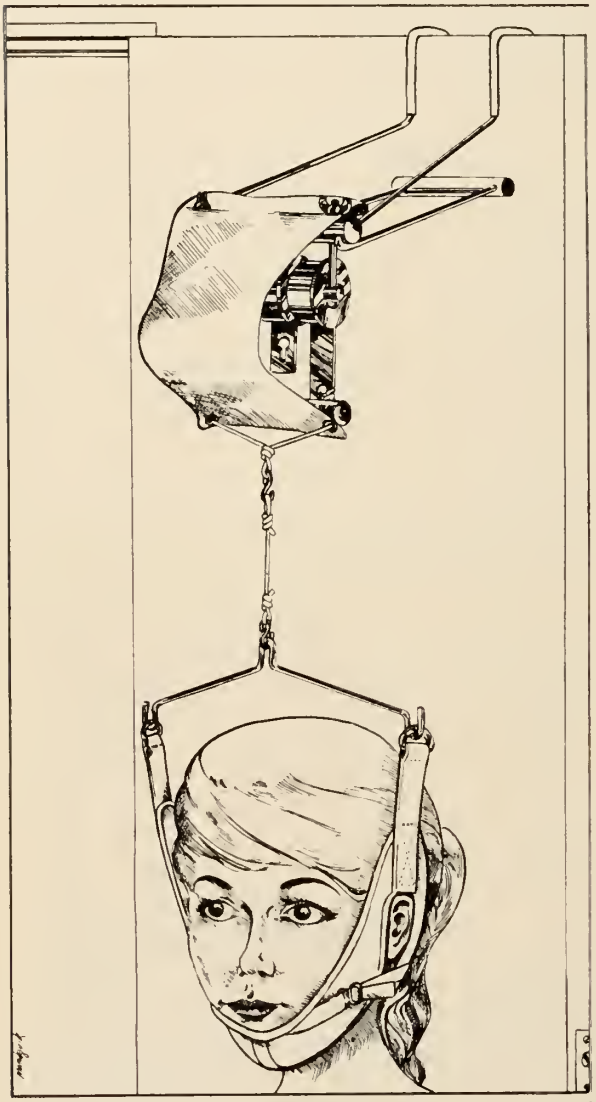
GIVEN AWARD—W. H. Huron, M.D., Iron Mountain, was presented the annual "National Divisional Award" by the Michigan Division of the American Cancer Society at its recent convention in Kalamazoo. This highest award of the American Cancer Society was presented in recognition of the many years of outstanding service given by Doctor Huron to the causes of cancer education and control.

APPOINTED—Donald William Martin, M.D., superintendent of Summit County Receiving Hospital, Ohio, since 1959, will become medical superintendent of Pontiac State Hospital November 20. Doctor Martin will fill the position occupied for several years by Walter H. Obenauf, M.D., who died in July. Summit County Hospital is an intensive treatment unit operated by the Ohio Division of Mental Hygiene.



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REPRESENTS MHA—Among the delegates at the State Leadership Conference on Mental Health October 1 at East Lansing was James T. Howell, M.D., Detroit, representing the Michigan Hospital Association.

MCCC SPEAKER—Dean Millard, D.D.S., of Ann Arbor, spoke to the Jackson District Dental Society on October 9 on the subject "Recognition of Oral Cancer." The speaker was secured through the Michigan Cancer Coordinating Committee, Box 152, East Lansing.

CO-DIRECTORS—The American College of Physicians held a postgraduate course in "Recent Advances in Basic Mechanisms in Internal Medicine" at the University of Michigan Medical Center October 7-11. William D. Robinson, M.D., and John M. Weller, M.D., served as co-directors.

HONORED—David Van Ginkel, M.D., of Des Moines, who served his internship at the Wayne County General Hospital, Garden City, has been awarded a Wyeth Laboratories residency fellowship in pediatrics. The $4,800 fellowship, sponsored by the Wyeth Fund for Postgraduate Medical Education, is one of fifteen granted this year.

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IN MEMORIAM

GUY D. CULVER, M.D., 70, Stockbridge physician for 35 years, died August 27, 1963.

A graduate of the University of Michigan Medical School in 1926, Doctor Culver came to Stockbridge in 1927 and practiced there until his death.

He was a Past President of the Jackson County Medical Society, former Stockbridge Village President, and was a retired member of the Michigan State Medical Society.

GEORGE R. HANKE, M.D., 80, Ransom practitioner since 1911, died September 20, 1963.

A graduate of Detroit Homeopathic College in 1907, Doctor Hanke was a Past President of the Hillsdale County Medical Society. He was a Life Member of the Michigan State Medical Society.

CLYDE S. W. MARTIN, M.D., 65, former Port Huron surgeon, died September 2, 1963, at Winter Park, Florida.

A 1934 graduate of the University of Nebraska Medical School, Doctor Martin came to Port Huron in 1937. Before retiring to Florida in 1956, he was a chief of staff at Port Huron Hospital and on the staff of Mercy Hospital, Port Huron.

Memberships included the American Ambulatory Fracture Association and Alpha Omega Alpha medical fraternity. He was a Fellow of the International College of Surgeons and of the American College of Surgeons. He was a retired member of the Michigan State Medical Society.

ALEXANDER M. STIRLING, M.D., 78, retired Detroit area surgeon, died August 25, 1963.

Doctor Stirling retired in 1958 after practicing 52 years in the Detroit area. He was a member of the International College of Surgeons and a retired member of the Michigan State Medical Society.

RUDOLPH G. TENEROWICZ, M.D., 73, Hamtramck physician and surgeon and former Hamtramck mayor, died August 31, 1963.

A graduate of Loyola University Medical College, Chicago, he began his medical practice in Chicago in 1912, moving to Hamtramck in 1923, following medical corps service in World War I.

Doctor Tenerowicz had served on St. Francis Hospital staff since 1929, and was honorary life chief of staff at Holy Cross Hospital.

He was a member of many medical organizations and a Life Member of the Michigan State Medical Society.

DAVID R. WARK, M.D., 73, Flint surgeon for 38 years, died August 21, 1963.

A graduate of the University of Manitoba medical school, Doctor Wark did postgraduate work at the Royal College of Physicians and Surgeons in Edinburgh, Scotland. He was on the staffs of Hurley, McLaren General and St. Joseph Hospitals in Flint.

Doctor Wark was a Life Member of the Michigan State Medical Society.

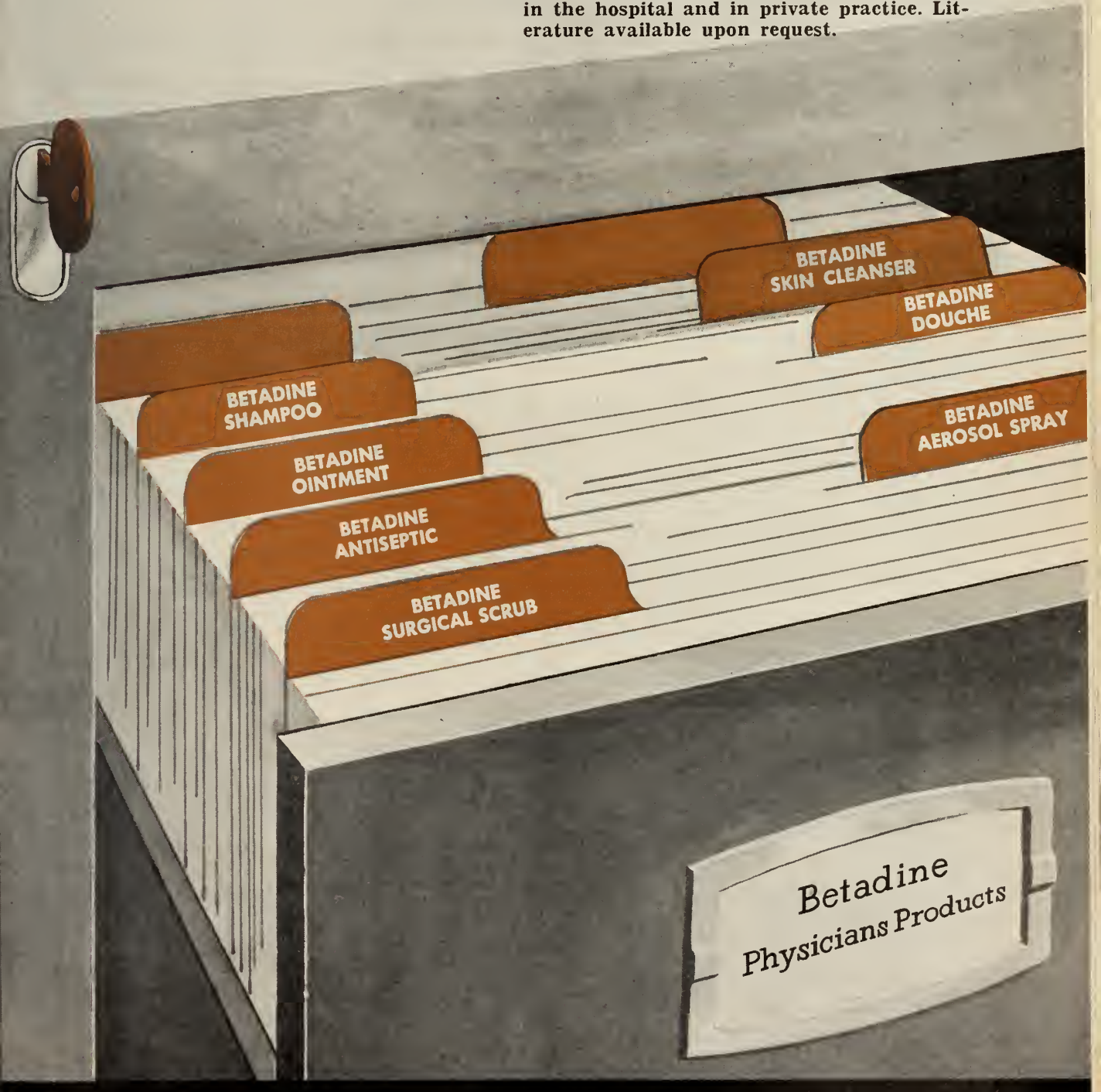
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Michigan Authors

A. R. Vanden Berg, M.D., and C. M. Vasu, M.D., Grand Rapids, "Polycythemia Associated with Uterine Fibroma," *Journal of the American Medical Association*, July 27, 1963.

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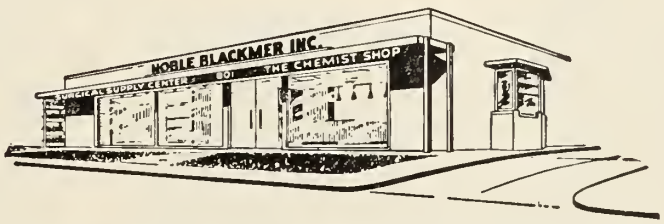
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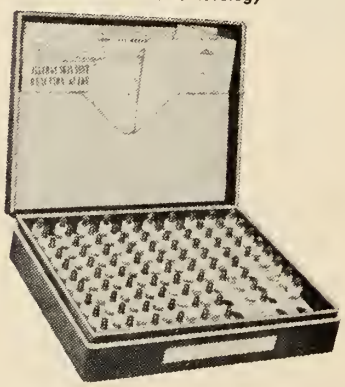
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Letters to the Editor

Dear Editor:

Enclosed find copy of Resolution recently passed by the Michigan State Board of Registration in Medicine at the last regular Board Meeting, and the Board policy regarding Osteopaths.

We have had several inquiries regarding these matters and the Board felt it would be wise to publish this data for the information of the profession.

Sincerely yours,
E. C. Swanson, M.D.
Executive Secretary
Michigan State Board of Registration in Medicine

Lansing, Michigan
October 10, 1963

RESOLUTION

1. Whereas, complaints and information indicate that M.D.s with temporary licensure for post-graduate training may be working in non-approved hospitals, physicians' offices and clinics, and

2. Whereas, inquiry reveals a lack of knowledge of the law restricting residents to work in a designated training hospital, and

3. Whereas, the law governing the issuance of temporary medical license for post-graduate training provides for the summary revocation of such temporary license for such violation, and

4. Whereas, this Board strongly prefers to help maintain legal licensure rather than to discipline illegal procedures; now, therefore, be it known that:

The Michigan State Board of Registration in Medicine, in regular meeting in Lansing this 3rd day of October, 1963 does hereby:

Resolve that each Superintendent of each hospital in Michigan, designated and approved for the post-graduate training of medical doctors, be advised of the provisions of Section 3, second, Act 237 of the Public Acts of 1899, as amended, and that he be requested to notify every medical resident assigned to his hospital of these legal restrictions, and, be it further

Resolved that this resolution and the law in question be sent to the Michigan State Medical Society with a request that they be publicized in the Michigan Medical Journal and made available for publication in any County Medical Society organization.

Michigan State Board of Registration in Medicine
By: E. C. Swanson, M.D.
Executive Secretary

POLICY ON OSTEOPATHS

On May 9, 1962, the Council on Medical Education and Hospitals issued the following statement on "Approved Intern and Resident Programs and Physicians Granted M.D. degrees by the California College of Medicine."

The California College of Medicine was accredited as a

medical school on February 15, 1962. Students now regularly enrolled in the 4th year class who graduate from that institution in June 1962 and subsequent regular graduating classes will be eligible for approved intern and resident positions on the same basis as graduates of all other approved medical schools.

As part of the California unification program, osteopathic physicians who are fully licensed in California and who otherwise are considered eligible will be issued M.D. degrees by the California College of Medicine. The Council on Medical Education and Hospitals of the American Medical Association has determined that physicians issued the M.D. degree under these circumstances *may be appointed to approved intern and resident programs located in the State of California without jeopardy to the approved status of the program.* Hospitals in California making such appointments are responsible to ascertain that the physicians are otherwise professionally and personally qualified for the positions to which they are appointed.

The secretaries of each of the state boards of medical licensure and secretaries of each American medical specialty board have been notified of the accredited status of the California College of Medicine. They were further notified that:

As a result of this action, the current fourth year class of the California College of Medicine, which will graduate in June, 1962, will be recognized as graduates of an accredited medical school. Graduates of that institution prior to February 15, 1962, are not affected and should not be recognized as graduates of an accredited school.

The Michigan State Board of Registration in Medicine maintains a list of the names of the acceptable graduates so that the same can be properly checked with the applications received by this Board.

E. C. Swanson, M.D., *Secretary*
Michigan State Board of
Registration in Medicine

* * *

About 170 county medical societies employ personnel to assist in developing public relations programs. These people usually are charged with the responsibilities of Executive Secretary or may serve as full or part-time PR Directors or PR Counsels.

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The Doctor's Library

Books received by THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY *are acknowledged in this column. Selections will be made for more extensive review in the interest of readers as space permits.*

HANDBOOK OF PEDIATRIC MEDICAL EMERGENCIES. Adolph G. DeSanctis, M.D., Professor Emeritus of Pediatrics, Post-Graduate Medical School, New York University-Bellevue Medical Center; Consultant in Pediatrics, University Hospital, New York University-Bellevue Medical Center, New York, N. Y., and Charles Varga, M.D., Chief, Department of Pediatrics, The Permanente Clinic and Bess Kaiser Hospital, Portland, Ore.; Clinical Instructor of Pediatrics, University of Oregon Medical School, Portland, Ore., and contributors. With eighty-five illustrations. Third Edition. Saint Louis: The C. V. Mosby Company, 1963. Price, $12.75.

This handbook divides the handling of emergencies into systems—cardiac, respiratory, neurological, et cetera. Everything is presented in a clear outline form. A great deal of information can be found with a minimum of effort.

There is a good chapter on pediatric procedures. Not many books include these practical "how to do it" procedures.

The handbook should be very useful to a generalist and to pediatricians.

F. J. MARGOLIS

ATLAS OF VASCULAR SURGERY. By Falls B. Hershey, M.D., F.A.C.S., and Carl H. Calman, M.D., F.A.C.S.; St. Louis: The C. V. Mosby Co., 1963. Price, $18.00.

This volume presents in a clear and concise fashion the diagnostic methods and techniques of vascular surgery. Each chapter is prefaced by introductory information concerning the entities for which the operation is to be considered. The text assumes a generalized familiarity on the part of the reader with the subject of vascular surgery and, consequently, does not dwell at length on theory and anatomy. The operative techniques are up-to-date and described in a clear fashion. The illustrations depict vividly the techniques described and the book is well organized and indexed.

The book is well printed and represents an excellent source of technical information for those interested in the current techniques of vascular surgery, both arterial and venous. It is an excellent volume.

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THE COMMUNITY GENERAL HOSPITAL. By Basil S. Georgopoulos and Floyd C. Mann. Philadelphia: Macmillan, 1962.

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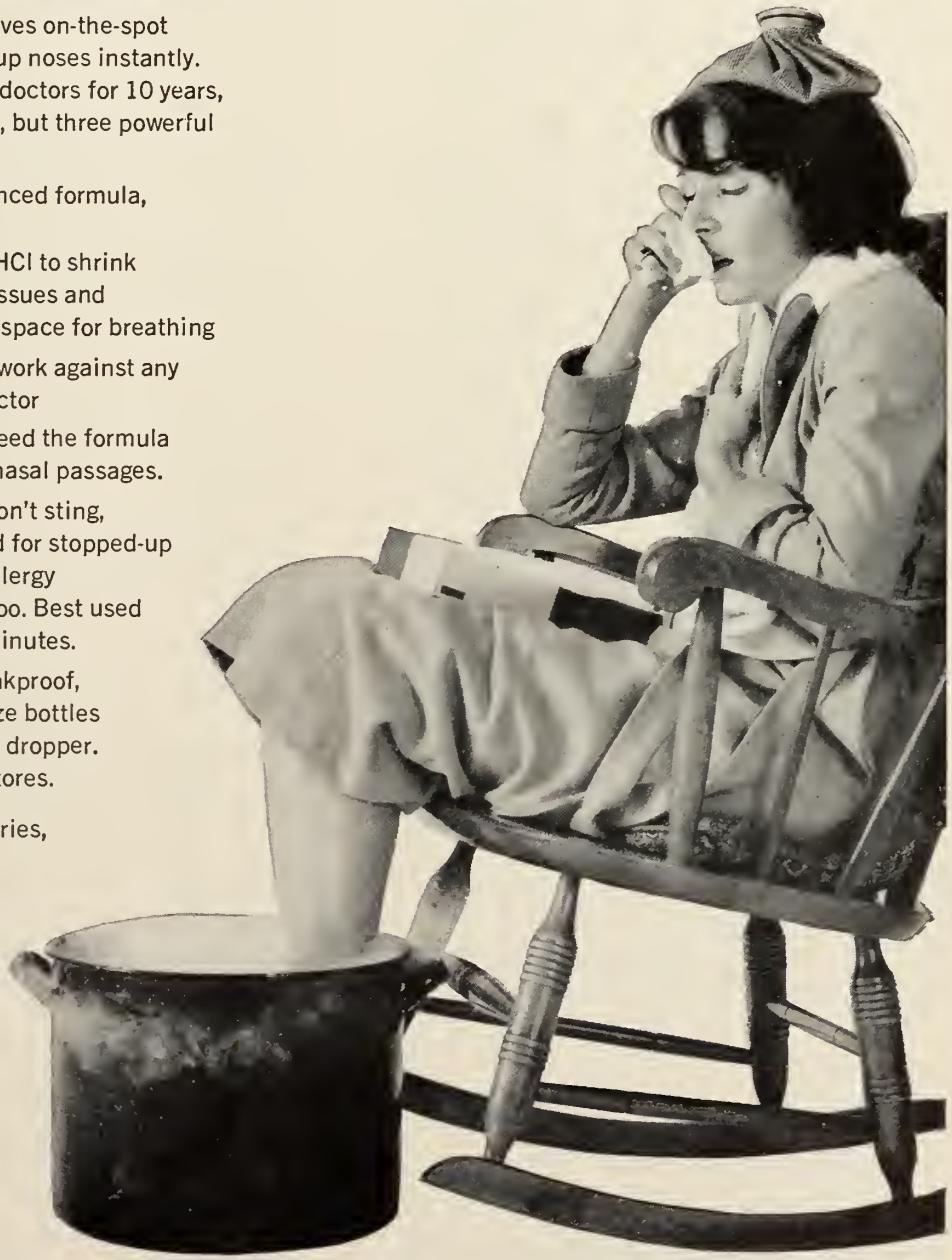
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The text is extremely comprehensive in its approach to the problems involved and as a result, it cannot be recommended for reading as a light novel, nor can it be described as being entertaining. Apparently, its greatest use will be to all members of the hospital medical care team who will avail themselves of those sections of the study which will be of direct interest to their area of work.

DANIEL N. FINCH

BOOKS RECEIVED

BABY AND CHILD CARE. By Dr. Benjamin Spock. Illustrations by Dorothea Fox. A Giant Cardinal Edition. New York: Pocket Books, Inc., 1963. Price, 50c.

FUNDAMENTALS OF VOLUNTARY HEALTH CARE. Edited by George B. De Huszar. Caldwell, Idaho: The Caxton Printers, Ltd., 1962. Price, $6.00.

SELECTIVE BIBLIOGRAPHY OF ORTHOPAEDIC SURGERY. Including a cumulative index of instructional Course Lectures. The American Academy of Orthopaedic Surgeons Committee on Teaching Aids: John Hamilton Allan, Francis J. Cox, Ernst Dehne, Garrett Pipkin, Carroll B. Larson, Chairman. Saint Louis: C. V. Mosby Company, 1962. Price, $2.90.

LOVE IN A DYING WORLD. Contemporary Poets of Dorrance (559). By Joan Rosenbaum, Philadelphia: Dorrance and Company, 1963. Price, $2.50.

RESISTANCE OF BACTERIA TO THE PENICILLINS. Ciba Foundation Study Group No. 13, in honour of Sir Charles Harington, K.B.E., Director, National Institute for Medical Research, 1942-1962. Edited by A. V. S. de Reuck, M.SC., D.I.C., A.R.C.S., and Margaret P. Cameron, M.A. 14 illustrations. Boston: Little, Brown & Company, 1962. Price, $2.95.

ACTIVITIES OF SURGICAL CONSULTANTS. Surgery in World War II. Medical Department, United States Army. Volume I. Prepared and published under the direction of Lieutenant General Leonard D. Heaton, The Surgeon General, United States Army. Editor-in-Chief, Colonel John Boyd Coates, Jr., M.C.; Editor for Activities of Surgical Consultants, B. Noland Carter, M.D.; Associate Editor,

Elizabeth M. McFetridge, M.A. Washington, D. C.: Office of the Surgeon General, Department of the Army, 1962. Price, $6.50.

WOUND BALLISTICS. Medical Department, United States Army. Prepared and published under the direction of Lieutenant General Leonard D. Heaton, The Surgeon General, United States Army. Editor-in-Chief, Colonel James Boyd Coates, Jr., M.C.; Editor for Wound Ballistics, Major James C. Beyer, M.C. Washington, D. C.: Office of the Surgeon General, Department of the Army, 1962. Price, $7.50.

TRANSPLANTATION. Ciba Foundation Symposium. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Margaret P. Cameron, M.A. With 71 illustrations. Boston: Little, Brown and Company, 1962. Price, $12.00.

THE FAT BOY GOES POLY-UNSATURATED. By Elmer Wheeler, Author of The Fat Boy's Book. Illustrated by David Pascal. Garden City, New York: Doubleday & Company, Inc., 1963. Price, $3.50.

DICTIONARY OF EROTIC LITERATURE. By Harry E. Wedeck, Lecturer in Classics, Brooklyn College, N. Y.; Fellow, International Institute of Arts and Letters. New York: Philosophical Library, 1963. Price, $10.00.

BILHARZIASIS. Ciba Foundation Symposium Held in Commemoration of Theodor Maximilian Bilharz. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Maeve O'Connor, B.A. 46 illustrations. Boston: Little, Brown and Company, 1962. Price, $11.50.

PROTEIN METABOLISM. Influence of Growth Hormone, Anabolic Steroids, and Nutrition in Health and Disease. An International Symposium Leyden, June 25-29, 1962. Sponsored by Ciba; Chairman, A. Querido, Leyden. Edited by F. Gross, Basle. 159 figures. Berlin-Goettingen-Heidelberg: Springer Verlag, 1962. (No price given)

INTESTINAL BIOPSY. Ciba Foundation Study Group No. 14. In honour of Professor C. Jime'nez Diaz. Edited by G. E. W. Wolstenholme. O.B.E., M.A., M.B., M.R.C.P. and Margaret P. Cameron, M.A. 53 illustrations. Boston: Little, Brown and Company, 1963. Price. $2.95.

THE CARE OF MINOR HAND INJURIES. By Adrian E. Flatt, M.A., M.D., F.R.C.S., F.A.C.S., Associate Professor of Orthopedic Surgery, University of Iowa, Iowa City, Iowa; Hunterian Professor, Royal College of Surgeons of England. With Forewords by Carroll B. Larson and Sir Reginald Watson-Jones. Second edition. 120 figures. Saint Louis: C. V. Mosby Company, 1963. Price, $10.50.

THE SPECIFICITY OF SEROLOGICAL REACTIONS. By Kar Landsteiner, M.D. With a Chapter on Molecular Structure and Intermolecular Forces by Linus Pauling and a Bibliography of Dr. Landsteiner's Works and a New Preface by Merril W. Chase, The Rockefeller Institute. New York: Dover Publications, Inc., 1963. Price, $2.00. Revised Edition.

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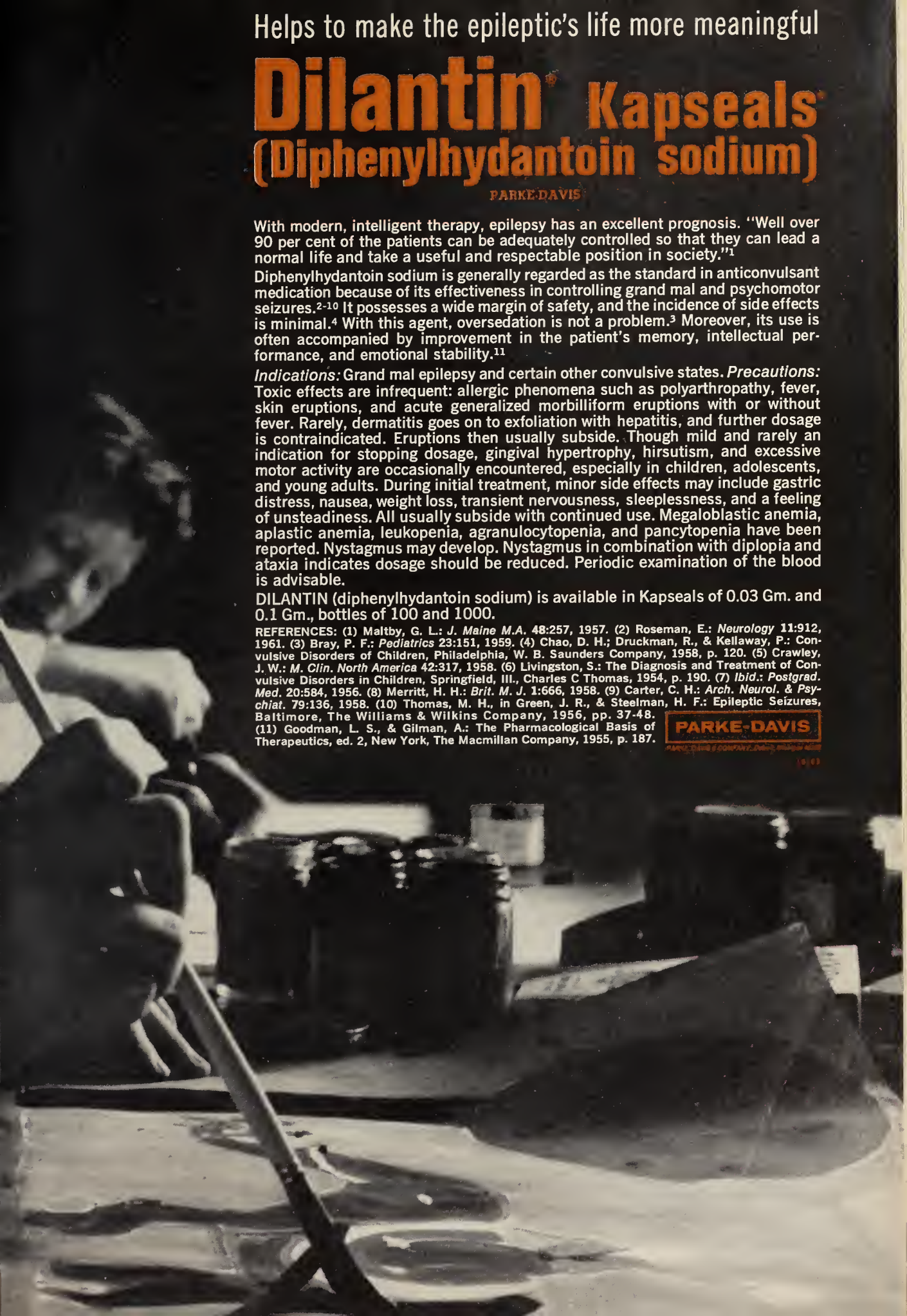
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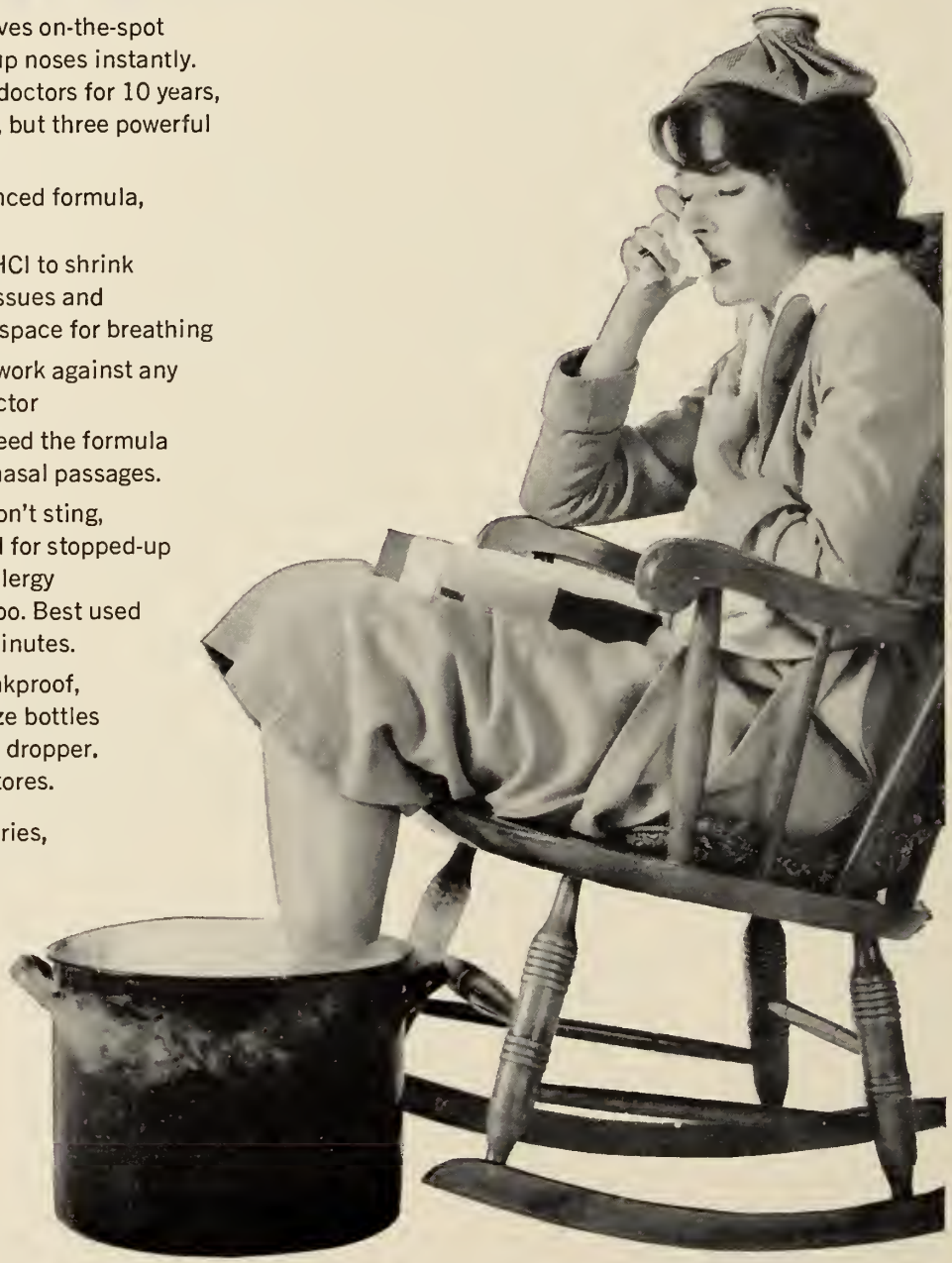
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Delegates

	Term Expires
J. R. Heidenreich, M.D., Daggett	1963
W. A. Hyland, M.D., *Chairman*, Grand Rapids	1963
O. J. Johnson, M.D., Bay City	1963
L. R. Leader, M.D., Birmingham	1963
C. I. Owen, M.D., Detroit	1964
G. W. Slagle, M.D., Battle Creek	1964
D. N. Sweeny, Jr., M.D., Detroit	1964

Alternates

	Term Expires
G. B. Saltonstall, M.D., Charlevoix	1963
J. M. Wellman, M.D., Lansing	1963
Sidney Adler, M.D., Detroit	1963
B. M. Harris, M.D., Ypsilanti	1963
R. E. Rice, M.D., Greenville	1964
A. Hazen Price, M.D., Detroit	1964
E. E. Martmer, M.D., Grosse Pte	1964



In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain...not the patient").*

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

Soma® Compound

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

Soma® Compound + Codeine

carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning—may be habit forming.)

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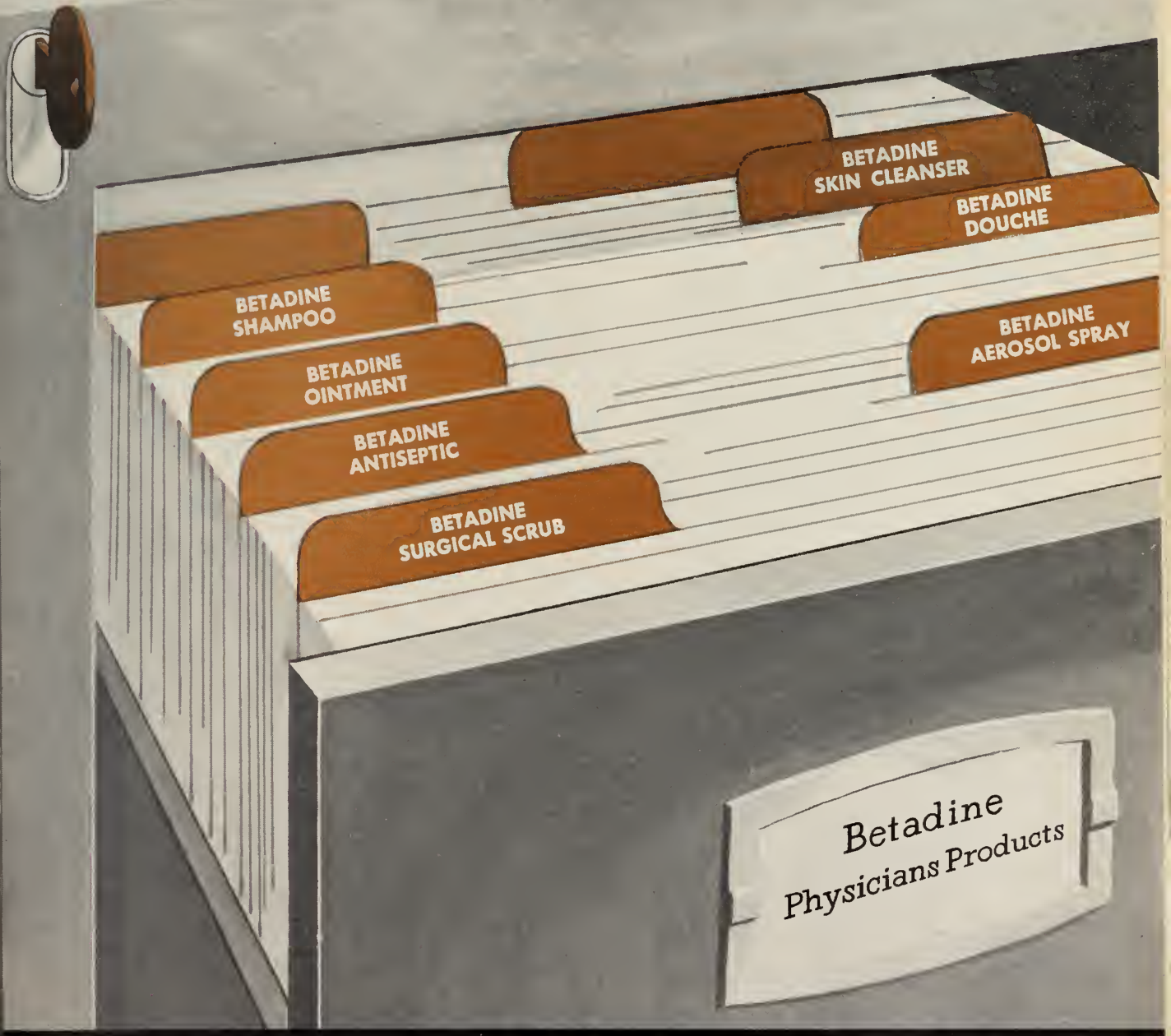
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The clinical results reported under various conditions of use make Betadine (povidone-iodine) preparations valuable adjuncts both in the hospital and in private practice. Literature available upon request.



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President's Page

THE ROLE OF BLOOD BANKS



Arlen J. Johnson M. D.

President
Michigan State Medical Society

One phase of medical progress which is vital but not too well recognized or appreciated is the role of blood banks. Thirty years ago, transfusions were cumbersome, frequently unsuccessful and fraught with some danger.

The refinements in the collection, preservation and storage and administration of blood parallel or exceed other medical advances. In fact some facets of medical achievement would not be possible without the availability of blood. The heart-lung machine requires 20 pints for priming, the kidney machine 10 to 15 pints and many prolonged surgical procedures are completely dependent on blood replacement.

The blood bank organizations which are keys to this service are part of organized medicine. By cooperation they have been instrumental in developing programs throughout the country so that essentially all parts of the U. S. have blood available. The American Association of Blood Banks Clearing House makes it possible for patients to receive this service wherever they may be in their travels.

From the economic side, the increased cost of individual transfusions has been minimal compared to other goods and services. The increases being in the cost of equipment for administration and labor.

The teams involved in the over-all blood bank programs are composed of medical technicians as well as physicians. The technical improvements for the handling and administration of blood are under constant study. Typing and study of the factors within the blood are receiving considerable attention.

This is another part of the story of the efficiency, incentive and ingenuity of free enterprise in medicine. It is another chapter in the story that needs to be told again and again to the American public.

* * *

May I take this opportunity personally to wish you and yours "Holiday Greetings" and extend also my personal wishes for a "Happy and Successful 1964."

State Among Leaders For Postgraduate Efforts

By JOHN M. SHELDON, M.D., *Chairman*
MSMS Postgraduate Education Committee



A national reputation for the variety of postgraduate courses and the number of doctors who participate has been attained in Michigan. These offerings are designed to keep practicing physicians, both family doctors and specialists, up-to-date with the rapid advances taking place in the science and practice of medicine.

The MSMS extramural postgraduate program for 1963 was held in twenty-one centers of Michigan and was presented to over 900 doctors in the State.

Many of the centers in which these programs are offered have a small number of doctors, but they are enthusiastic in their appreciation for the stimulating spring and autumn clinical sessions and look forward to them as highlights of their societies' activities. All-day clinics have been held in some of the larger centers. Whenever it is possible, panels are utilized to present a topic rather than lectures by individuals.

The program is sponsored by the Wayne State University College of Medicine, the Michigan State Medical Society, the Michigan Department of Health, and the University of Michigan Medical School. The teaching activities are participated in by members of the faculties of the Wayne State University and the University of Michigan.

Along with the extramural courses, practicing physicians from 30 States and Canada participated in the 34 postgraduate programs and conferences offered at The University of Michigan Medical Center during 1962-63 academic year. A record number of 2,624 doctors took one or more of the different courses offered by the Faculty. Length of the courses varied from half a day to seven months. Thirty-one courses will be offered during the current academic year. The first course began on September 12, 1963, and the last course is scheduled to end on May 29, 1964. Five of these will be "drive-in" courses for doctors living within easy commuting distance of the U-M Medical Center. Three will meet in the afternoons and two will be held in the evenings.

A great number of postgraduate educational opportunities for short, intensive, refresher courses, including weekly one- and two-hour sessions, are offered by Wayne State University College of Medicine. These excellent programs are especially attractive to those doctors living in Wayne County and nearby to these facilities.

Much effort is being made in Michigan to learn the need for improvement in practice along certain lines and the desires of the physicians so that a realistic approach may guide the expansion of these educational opportunities.

Statement of Principles for Hospitals, Lawyers and Doctors With Respect to Hospital Records and Contact Between Lawyers and Patients

(The following statement has been approved by the governing boards of the Michigan State Medical Society, State Bar of Michigan and the Michigan Hospital Association. The MSMS Council, at its September meeting, authorized its publication in the MSMS JOURNAL*).*

The State Bar of Michigan, the Michigan State Medical Society, and the Michigan Hospital Association, recognizing the need for a Statement of Principles for the Guidance of the Members of the Several Associations with respect to the handling of hospital records and relationships between attorneys and patients in hospitals arising from litigation or contemplated litigation based upon personal injuries, do adopt and publish the following general statement of principles in the hope that the members of the several associations will be guided by these principles in their day-to-day relationships, to the end that the health and welfare of the patient will not be jeopardized, that the hospitals and hospital personnel will not be unnecessarily inconvenienced, that the legal privileges of patients shall not be circumvented, and that the legitimate interest of attorneys and the courts shall be served without undue difficulty:

1. It is recognized and accepted that the medical record is the property of the hospital. It is further recognized that hospital records relating to diagnosis, care and treatment of a hospital patient constitute the privileged information of the patient. However, the hospital is expected to assert such privilege for the benefit of the patient until such time as the release of such information is authorized by or on behalf of the patient, or until the production of such records is ordered by the courts. Attorneys shall not seek to obtain access to such records in the absence of a properly executed waiver of privilege or authorization by or on behalf of the patient, or court order. Whenever practicable, the physician should be notified that a request has been made for hospital records of his patient.

2. An authorization for the release of information contained in hospital records should be deemed adequate if it is in writing, signed by the patient if adult and competent, or by the patient's legal guardian if any, or in the event of a minor having no legal guardian by the parent having custody and supervision of said minor, or in the event of a deceased person by his legal representative, and dated subsequent to the records sought to be examined. Limitations contained in authorizations shall be respected by the hospital.

3. Any attorney or properly authorized person presenting a proper authorization may be permitted to review the hospital record of the patient, and upon request and payment of a reasonable fee based upon the cost thereof, may be provided with a copy of such medical record. Said authorization shall be retained by the hospital and kept with such records with a notation made showing the identity of the person presenting it, the date, and whether the records were examined or copies furnished.

4. In any case where hospital records are required to be introduced in evidence in any litigated matter, the attorneys involved therein may agree to accept the certificate of the medical record librarian or other custodian in lieu of testimony to qualify such records. Photocopies of hospital records should be accepted in lieu of original records.

5. In the event it shall be necessary to subpoena original hospital records and/or the custodian thereof, attorneys involved in the litigation shall cooperate in arrangements to minimize the inconvenience to hospital personnel. It shall be the obligation of the attorney and/or attorneys obtaining such records to see that they are returned promptly to the proper custodian in their original condition. Attorneys shall not remove medical records from the courtroom during the course of the trial unless they have the permission of the court. A receipt shall be given for such records. In the event that the hospital is required to provide medical records which are on microfilm it shall be the obligation of the attorney or attorneys to see that a viewer is provided for courtroom use.

6. Whenever it shall be necessary in any litigated matter to prove the amount of a hospital bill or any part thereof, the attorneys involved should endeavor to reach agreement with respect thereto so that it will not be necessary to call hospital personnel as witness to prove the amount of hospital charges.

7. When x-ray films are required in connection with any litigated matter, arrangements shall be made by the attorneys involved so that such films are returned to the hospital upon the conclusion of all testimony

Recipients of MSMS 50-Year Pins





It was a proud moment at the 1963 MSMS House of Delegates meeting when twelve MSMS members received their coveted 50-year membership pins. Waiting for introduction and their pins from MSMS officials are 50-year Men *(left to right)* Isaac S. Lilly, M.D., Stanton; Roy A. Morten, M.D., Kalamazoo; Dorsey W. Patterson, M.D., Port Huron; Milton C. Smith, M.D., Mount Clemens; F. G. Swartz, M.D., Traverse City; Stuart Wilson, M.D., Alpena; and in photo at right are *(left to right)* Leon M. Bogart, M.D., Flint; Clarence L. Candler, M.D., Detroit; Elisha W. Coster, M.D., Oak Park; Lowry C. M. Conley, M.D., Detroit; Frank B. Gerls, M.D., Pontiac; and Raymond E. Hellmer, M.D., Painesdale. Several others, who were unable to attend the House of Delegates meeting, also were approved for their 50-year recognition. The full list appeared in the November JOURNAL.

relating thereto or at the termination of the trial. Attorneys shall endeavor, insofar as possible, to dispense with the testimony of an x-ray technician, unless such testimony is essential to qualify the films.

8. The practice of the interchange of x-ray films between radiologists shall be encouraged.

9. Attorneys shall not attempt to interview patients in hospitals in such a manner as to interfere with the hospital routines or the care of the patient, nor when the patient is in such physical or mental condition, in the opinion of the attending physician, that his mental faculties are significantly impaired. Before interviewing a patient an attorney shall follow any reasonable procedure adopted by the hospital for guarding patients against unreasonable intrusions. Hospitals should not refuse any attorney the opportunity to interview a patient unless the health of the patient, in the opinion of the attending physician, would thereby be jeopardized, or unless, in the opinion of the attending physician, the patient is in such condition by reason of medication or injury or sickness that he is not in a fit condition mentally to be interviewed. Hospitals may, of course, regulate the time and manner and duration of such interviews so that they will not interfere unduly with hospital routines.

Named to State Board Of Registration in Medicine

Governor Romney has appointed the following new members to the State Board of Registration in Medicine:

Irving Kurtz, M.D., Detroit; Don M. McLean, M.D., Lathrup Village; C. Allen Payne, M.D., Grand Rapids; Frederick C. Sabin, M.D., Marquette, and Gilbert E. Saltonstall, M.D., Charlevoix. Those they will succeed on the 10-member board are Joseph P. Bertucci, M.D., Ishpeming; Paul G. Hanna, M.D., St. Joseph; Walter E. Mercer, M.D., East Lansing; Oscar D. Stryker, M.D., Mount Clemens, and Edward V. Williams, M.D., Muskegon.

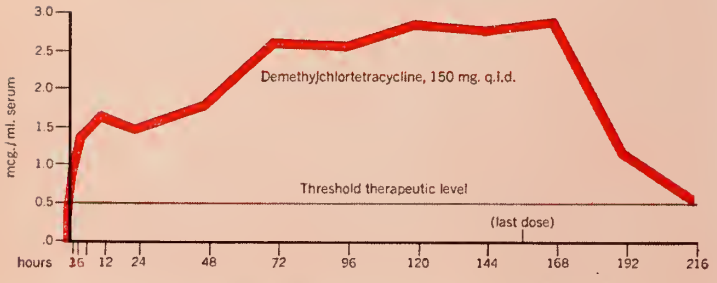
Wm. J. Burns Honored

Wm. J. Burns, MSMS executive director who will retire January 1, 1964, received a special award at the fall annual meeting of the American Cancer Society, Michigan Division. Mr. Burns has long been active in the many cancer-control efforts in Michigan and the Nation.

only 150 mg. versus 250 mg.

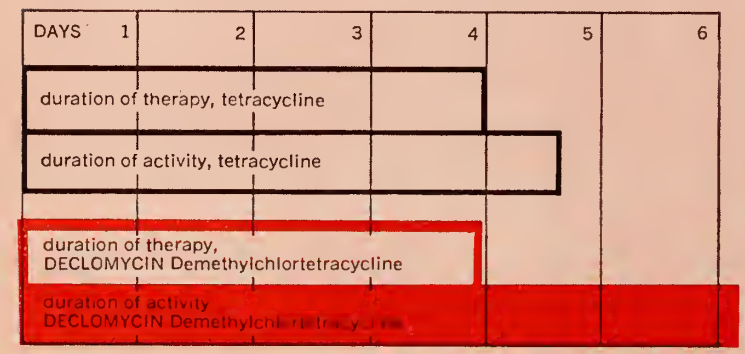


higher activity levels than other tetracyclines



From Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.: *Amer. J. Med. Sci.* 243:296 (Mar.) 1962.

1-2 days' "extra" activity





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DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE HCl

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive. *Side Effects* typical of tetracyclines which may occur: glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms. Also: photodynamic reaction (making avoidance of direct sunlight advisable) and, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. *Capsules,* 150 mg. and 75 mg. of demethylchlortetracyline HCl. *Average Adult Daily Dosage:* 150 mg. q.i.d. or 300 b.i.d.

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Meet the Members of the New MSMS Council



Seated front row *(left to right)*: E. E. Martmer, M.D., Grosse Pointe; W. A. Scott, M.D., Kalamazoo; C. Allen Payne, M.D., Grand Rapids; R. J. Mason, M.D., Birmingham; H. H. Hiscock, M.D., Flint; O. J. Johnson, M.D., Bay City; O. B. McGillicuddy, M.D., Lansing; J. J. Lightbody, M.D., Detroit.

Standing second row *(left to right)*: W. C. C. Cole, Sr., M.D., Detroit; J. R. Dehlin, M.D., Gladstone; J. J. Coury, M.D., Port Huron; C. I. Owen, M.D., Detroit; L. F. Hayes, M.D., Gaylord; C. J. Tupper, M.D., Ann Arbor; D. B. Wiley, M.D., Utica; W. A. Hyland, M.D., Grand Rapids.

Standing back row *(left to right)*: H. C. Hanson, M.D., Battle Creek; R. V. Daugharty, M.D., Cadillac; R. V. Taylor, M.D., Jackson; D. R. Smith, M.D., Iron Mountain; B. L. Masters, M.D., Fremont; D. W. McLean, M.D., Detroit; A. C. Stander, M.D., Saginaw; B. M. Harris, M.D., Ypsilanti.

Not present when the photo was taken at The Council meeting September 26, 1963, were: Harold Kessler, M.D., Alpena; E. J. Tallant, M.D., Detroit; and R. K. Whitely, M.D., Detroit.

MSMS Past Presidents Confer



Each year at the MSMS Annual Session a luncheon is held for the MSMS Past Presidents, so they can reminisce and also confer about current MSMS projects and activities. Present at the 1963 luncheon were *(left to right)* G. B. Saltonstall, M.D., Charlevoix; H. R. Carstens, M.D., Birmingham; B. R. Corbus, M.D., Grand Rapids; J. Milton Robb, M.D., Detroit; L. W. Hull, M.D., Detroit; C. I. Owen, M.D., Detroit; R. J. Hubbell, M.D., Traverse City; K. H. Johnson, M.D., Lansing; G. W. Slagle, M.D., Battle Creek; Otto O. Beck, M.D., Birmingham; E. F. Sladek, M.D., Traverse City.

National Recognition

"Leading up to its centennial in 1965, the Michigan State Medical Society is running a series of historical articles in its JOURNAL. The sequence began in the September issue with an account of the first 50 years, with particular reference to the inroads which the Civil War had made on the profession and to refinements in structure as the organization grew. It also listed all presidents who served between 1866 and 1914. The October installment told how one early member pioneered in human digestion. Monthly articles thereafter will bring the MSMS chronicle up to the 100th anniversary, to be observed at a meeting in Detroit."—*Association Newsletter*, October 1963, Vol. 9, No. 10.

Journal Recognition

The Ames Company's publication *LABQUICK* (Vol. 3, No. 6), mailed to all medical laboratory technologists and pathologists in the United States, contained an abstract from the July MSMS JOURNAL.

The MSMS article was entitled "Hemoglobin — Grams or Per Cent".

(Turn to Page 1156)

blood, milk and Maalox®

(magnesium-aluminum hydroxide gel)

Practically standard treatment, now, for bleeding ulcer. Why is Maalox included? Antacid therapy *must* continue long after the wound has healed, and patients started on Maalox tend to stay on Maalox. It tastes good; it's effective and will not cause constipation—three important reasons for Maalox over the long haul. Some physicians, we are told, order Maalox routinely for hospital patients on drugs which could irritate. They feel it reduces the likelihood of gastric discomfort. Supplied: Suspension; Tablets No. 1; Tablets No. 2. (Each Maalox No. 1 Tablet is equivalent to 1 teaspoonful and each Maalox No. 2 Tablet is equivalent to 2 teaspoonfuls of Suspension.)



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MSMS Contends King-Anderson "Not Needed"

Testimony questioning the need for the King-Anderson scheme and also citing the high cost of financing the proposal was given before the Ways and Means Committee of the U. S. House of Representatives by Otto K. Engelke, M.D., MSMS Past President, on November 21.

Michigan was one of 12 state medical societies which presented official testimony.

In declaring King-Anderson as not necessary or needed in Michigan, Doctor Engelke told the Congressional Committee how effective the Michigan Medical Assistance to the Aged Act is in Michigan:

"The Michigan Medical Assistance to the Aged (Kerr-Mills MAA) Act is doing the job, and no amount of emotion and illogical propaganda can change the fact that Michigan does not need the King-Anderson Bill.

* * *

"THE MAA WAS designed properly to meet the special needs of the aging population. Michigan's program for providing medical assistance to the aged is designed to give maximum help to those who need help."

Doctor Engelke reported that 55,096 certifications for necessary health care have been granted in the three-year-old MAA program. "A total of 15,566 were issued in the first year, 19,063 in the second, and 20,467 in the third. A total of more than $50,000,000 of federal, state, and county funds have been devoted to the health care of Michigan's senior citizens under this program in 36 months."

"We trust that Congress will permanently reject this King-Anderson proposal," the Doctor said, "for the limited hospital and medical benefits incorporated in it would provide only a minor fraction of those already provided by our present legislatively-adopted, locally-controlled, and voluntary Kerr-Mills MAA program."

* * *

"THE FACTS DO NOT cry out for the imposition upon our citizens of additional Social Security taxes which would extract over $100,000,000 from Michigan, in the first year alone, to furnish such limited hospital and medical benefits as proposed by the King-Anderson Bill to all, regardless of their lack of need for financial help."

Doctor Engelke told the Committee: "The record shows our State of Michigan was the first of the fifty States to enact legislation to implement the Kerr-Mills Law, and the record also shows that Michigan was the first to have its implementing program approved by the United States Department of Health, Education and Welfare. Michigan's program for providing medical assistance to the aged is designed to give maximum help to those who need help, and it has been doing the job for which it was intended!

"When the Congress enacted the Kerr-Mills Law, it gave to the States a tool by means of which they could solve such problems as existed within their several borders with respect to those persons, 65 years of age and over, who are able to provide for their own needs of daily living but cannot afford a medical emergency."

* * *

THE MSMS REPRESENTATIVE also declared, "It is true that Michigan's Medical Assistance to the Aged program, like any other instrument, can undoubtedly be perfected. It is being continually analyzed and improvements found to be necessary will be made, with the encouragement and support of Michigan's Doctors of Medicine."

Doctor Engelke said the doctors of Michigan also opposed the King-Anderson Social Security approach because it would hit hardest those earning $5,200 or less. "We are mindful of the fact that the vast majority of individual Society Security taxpayers are those earning $5,200 per year or less."

"The proponents of this bill, who claim that America needs this multi-billion-dollar, payroll tax financed and federally controlled plan, should prove the need for it with facts," said Doctor Engelke. "They will not find their proof in Michigan."

Doctor Engelke described a spot survey conducted in Michigan at 182 general hospitals. The total adult population at the 182 hospitals was surveyed by the Michigan Hospital Association "on a day selected at random, July 11, 1963, to determine how each bill was actually paid."

* * *

"SEVENTY-SEVEN PER CENT of those over age 65 in the hospitals that day did not require any public assistance," he reported, "and all but 2 per cent of the total were either paying the bill themselves, covered by insurance, or receiving the care through an already existing public program." (EDITOR'S NOTE: Details on the survey will appear in January issue of THE JOURNAL.)

"A survey conducted in the same fashion in 1962 indicated that only 3.3 per cent of the total adults hospitalized in 174 hospitals were not covered by an existing program, by insurance, or able to pay the bill themselves," said Doctor Engelke. "Even though this percentage is remarkably small, obvious progress is being made toward eliminating it entirely."



Smooths out emotional peaks and valleys

'Meprospan'-400 brand of meprobamate contains 400 mg. in sustained-release form. One capsule smooths out the anxious patient's emotional peaks and valleys for 10 to 12 hours — and provides these other advantages:

1. **Especially suitable for maintenance therapy.** Patients whose anxiety has diminished to a mild or moderate level still require a certain amount of tranquilization throughout the day. Sustained-release action is ideally suited to this type of patient.
2. **Simpler dosage schedule.** Since one capsule of 'Meprospan'-400 (meprobamate, sustained release) acts 10 to 12 hours, the patient enjoys a much simpler dosage schedule than with tablets — and is less likely to forget to take the medicine.

Side Effects: Rarely, skin reactions. May increase effects of excessive alcohol. Use with care in patients with suicidal tendencies. Massive overdosage may produce coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence in patients with history of drug or alcohol addiction.

Available: *'Meprospan'-400* (meprobamate, sustained release) contains meprobamate 400 mg. *'Meprospan'-200* (meprobamate, sustained release) contains meprobamate 200 mg. Both potencies in bottles of 30. **Usual dosage:** One 400 mg. capsule or two 200 mg. capsules at breakfast; repeat with evening meal.

Meprospan®-400
meprobamate 400 mg.
sustained release

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New and revolutionary, the Thermo-Magic Refrigerator by Whirlpool uses the magic of thermoelectrics to chill and freeze. No liquid refrigerant, no coils, no compressor in these phenomenal thermoelectric units. And you can take the Thermo-Magic Refrigerator wherever you go, from room to room, in car or boat or out-of-doors . . . simply plug the unit into an ordinary 115-volt electrical outlet in a house or connect it to a 12-volt battery. Truly, this is one of the fascinating products that is helping to make the promised wonder-world of tomorrow a reality today.



Versatile Thermo-Magic Model 35 is made-to-order for businessmen . . . it's small enough to fit on a desk top or bookcase and it has no compressor to make noise. Doctors, dentists, physicists, lawyers, engineers, technicians, salesmen of all kinds . . . anyone with on-the-spot or on-the-go refrigeration needs can satisfy them with the lightweight, portable, efficient Thermo-Magic Model 35 Refrigerator.

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Please send me full details on your thermoelectric refrigerator and freezer.

Name

Address

City..... State

MSMS, Muskegon Society Say "Thanks" to Wm. M. LeFevre, M.D.

Officers of the Michigan State Medical Society joined the Muskegon County Medical Society recently in honoring Wm. M. LeFevre, M.D., long-time MSMS Councilor from the Muskegon-Western Michigan district.

An appreciation citation was presented from MSMS, a similar citation was offered by the delegates of that district, and the Muskegon County Medical Society gave Doctor LeFevre a watch.

Tributes to Doctor LeFevre for his 10 years of service on The MSMS Council and continuing service to MSMS committees were expressed by MSMS President O. J. Johnson, M.D.; Council Chairman Harold H. Hiscock, M.D.; President-Elect O. B. McGillicuddy, M.D.; Secretary D. Bruce Wiley, M.D.; and Councilor C. Allen Payne, M.D.

Doctor LeFevre was not a candidate this fall for re-election to The MSMS Council, and has been succeeded by Brooker L. Masters, M.D., Fremont.

MSMS Representatives Speak At Medical Journal Workshop

More than 125 participated in the recent annual conference in Chicago for editors, managing editors and business managers of the state medical society journals. The program covered not only the production aspects of scientific medical journals but also the advertising side of the journals.

C. J. Tupper, M.D., Ann Arbor, Scientific Editor of THE JOURNAL MSMS, moderated a panel program. Herbert A. Auer, MSMS managing editor, presented an address as part of a symposium.

Michigan Medical Meetings

Congress of the Professions, February 7-8, Jack Tar Hotel, Lansing.

Third Annual Canadian-American Medical and Dental Ski Association, Feb. 17-19, Harbor Highland, Harbor Springs, T. J. Trapasso, M.D., Sault Ste. Marie.

Genesee County Medical Society "Alcoholism Day," February 19, Hurley Hospital, Flint.

Michigan Heart Association "Heart Day," February 22, Statler-Hilton, Detroit.

Michigan Clinical Institute, Sheraton-Cadillac, March 11-13, Detroit.

Michigan State Medical Assistants Educational Seminar, March 11, Statler-Hilton, Detroit.

Wayne State University Clinic Day and Alumni Reunion, May 20, Detroit.

Say you saw it in the Journal of the Michigan State Medical Society

Important news in cardiac therapy

Two new clinical reports document successful long-term treatment of ischemic heart disease with

Persantin®, brand of dipyridamole

See next 3 pages

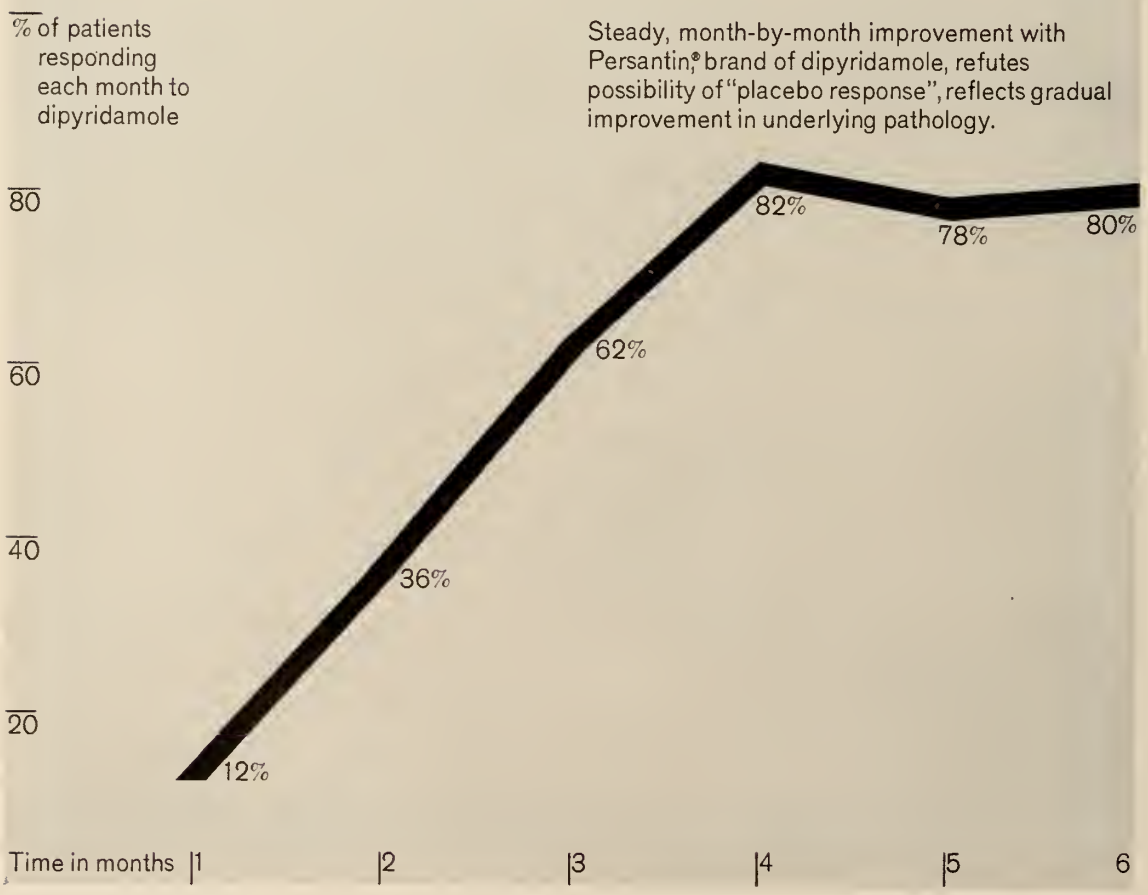
Study 1.
Griep,A.H.: Long-term Therapy of Ischemic Heart Disease With Oral Dipyridamole:
A Report of Fifty Cases. Angiology 14:484, 1963.

Persantin,® brand of dipyridamole, 25 mg. t.i.d. or q.i.d.,was administered continuously for 6 months to 50 patients with well authenticated ischemic heart disease with angina pectoris and ECG abnormalities. Results were evaluated on a monthly basis.

Persantin® brand of dipyridamole

"...long-term oral therapy with dipyridamole was of benefit in 80 per cent of the patients...

"relief [of angina] came slowly and was usually maximal after three to six months of continuous treatment"



Say you saw it in the Journal of the Michigan State Medical Society

Study 2.
Wirecki,M.: Dipyridamole (Persantin®): Evaluation of Long-Term Therapy in Angina Pectoris. Current Therapeutic Research 5:472, 1963.

In 40 ambulatory patients with myocardial ischemia, angina pectoris, and abnormal ECG findings, Persantin,® brand of dipyridamole, 25 mg. t.i.d., was administered continuously for 3 months.

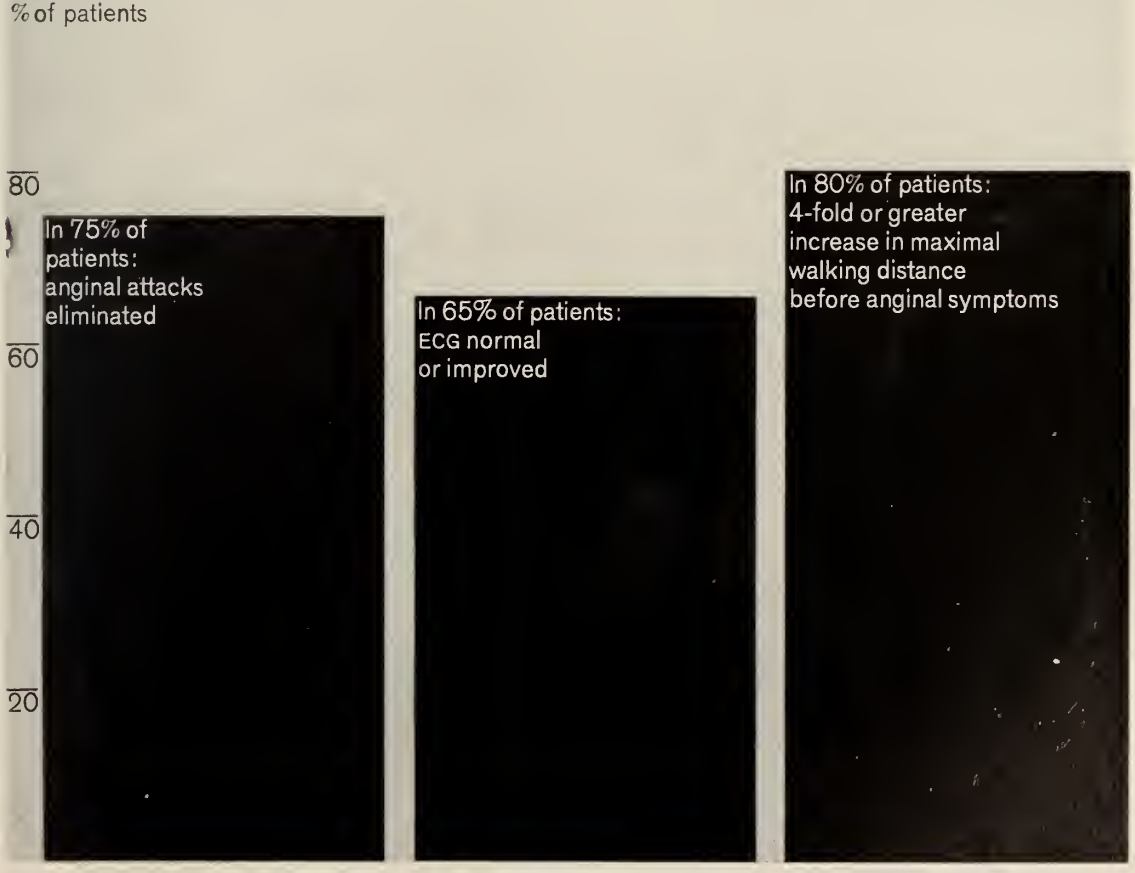
Geigy

After 3 months, 32 of 40 patients showed:

"...reduction or abolition of acute anginal attacks...

"complete or almost complete disappearance of ECG abnormalities...

"marked increase" in walking distance without anginal symptoms



Persantin® brand of dipyridamole

How long-term therapy provides clinical benefits reported on previous pages

1. By increasing energy yield
of the hypoxic myocardial cell, by direct action upon the sarcosomes (heart mitochondria).[1-5]

2. By improving collateral coronary circulation.
Prolonged oral administration of dipyridamole to animals with experimentally induced stenosis of a major coronary artery resulted in superior development of collateral coronary anastomoses and longer survival compared with controls.[6-9]

When given for prolonged periods and in adequate dosage, dipyridamole improves the coronary flow deficit of the ischemic myocardium while supporting cardiac metabolism during the period of repair. Clinically, this is manifested as steady improvement – anginal attacks diminish in frequency and intensity, as do other manifestations of insufficiency (dyspnea, fatigue, and, in many instances, abnormal electrocardiographic findings).

Availability:
Tablets of 25 mg., bottles of 100 and 1000.
Under license from Boehringer Ingelheim G.m.b.H.

Prescribing summary: Persantin,® brand of dipyridamole, is indicated in coronary and myocardial insufficiency, in a dosage of 2 to 6 tablets daily in divided doses before meals for several weeks. Side effects (headache, dizziness, nausea, flushing, weakness, syncope, mild gastrointestinal distress) are minimal and transient. The drug is not recommended in the acute phase of myocardial infarction, and should be used cautiously in hypotension.

References: 1.Kunz,W.;Schmid,W.,and Siess,M.: Arzneimittel-Forsch.12:1098,1962. 2.Siess,M.: Arzneimittel-Forsch.12:683,1962. 3.Laudahn,G.: Experientia 17:415,1961. 4.Lamprecht,W.: 27th Congress of the German Society for Circulation Research,Bad Nauheim,1961. 5.Hockerts,T.,and Bögelmann,G.: Arzneimittel-Forsch.9:47,1959. 6.Vineberg,A.M.,et al.: Canad.M.A.J.87:336,1962. 7.Chari,S.R.,et al.: Presented at the International Congress of Chest Physicians,New Delhi,1963. 8.Neuhaus,G.,et al.: Presented at the Fourth World Congress of Cardiology,Mexico City,1962. 9.Asada, S.,et al.: Japanese Circ.J.26:849,1962.

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PE-2290

Say you saw it in the Journal of the Michigan State Medical Society

Doctors Help Staff New Saginaw Clinic

Members of the Saginaw County Medical Society are playing a prominent part in the staffing of the new Saginaw Community Clinic, which opened in October. The Clinic is the outgrowth and normal development of two small private clinics which have been attempting to care for the medical needs of the underprivileged in Saginaw.



The First Ward Community Center, a settlement house located in a predominantly Negro district, has conducted a prenatal clinic since 1936 and a well-baby clinic since 1939. These were staffed through cooperation with the Visiting Nurse Association and the residents in Obstetrics and Pediatrics of the Saginaw General Hospital and financed through the Community Fund. The Guadalupe Center Clinic was started by the late Msgr. Harold Bolton, pastor of St. Joseph Church, in 1946. This was a general medical clinic and served primarily the needs of the Mexican population. It was staffed first by volunteers from the Saginaw County Medical Society and, since 1948, by residents from the Saginaw General Hospital. In 1952 St. Mary's Hospital interns and residents also took part in the work and, in 1960, St. Luke's Hospital began to participate. The work was done under the supervision of staff physicians from the different hospitals.

* * *

THE PHYSICAL setup of both clinics left much to be desired. Guadalupe Clinic in particular, located in a small remodeled house, was grossly inadequate and over-crowded. For many years the Mission Sisters of the Holy Ghost, who supervised the clinic, had been trying to interest the public in providing a more suitable building. Doctors who had for long contributed both their interest and their time of the project, particularly Donald Sargent, M.D., Laurence Bruggers, M.D., and Robert Lurie, M.D., succeeded in attracting the attention of two prominent Saginaw businessmen to the need. These men, James Smith, formerly of General Motors, Alex Levinsohn and Herman Bickel, spent weeks looking into the different aspects of the problem and then called a general meeting for public discussion. It was agreed that:

1. A new clinic should be formed that should be representative of all community needs.
2. That this clinic should have a Board of Directors composed of doctors, laymen and a representative of the Catholic Diocese of Saginaw, since the Sisters would continue to direct the work of the clinic.
3. That an attempt should be made to secure sufficient funds locally so that no national or federal funds would be needed.

These aims have been fully met. Three local trust funds, the Wickes Foundation, the C. K. Eddy Fund and the Boutell Fund, con-

tributed each one-third of the money needed to construct a modern and efficient clinic. Land was secured, partly through a gift by the city and partly through purchase, in an urban renewal section of the city close to many low-income homes. The new clinic provides six examining rooms, a large waiting room with an adjoining fenced playground, a small laboratory, offices, staff rooms and a drug room. This last is important since full use is made of sample drugs which can be dispensed free of charge to the patients.

* * *

THERE IS CLOSE cooperation between the clinic and the local hospitals, each of which provide interns, residents and staff supervision for "their" day of the week. Wherever possible the patients continue to come on the same day of the week so that there is continuity of treatment. Also hospitalization, x-rays, physical therapy, etc., is arranged for at the hospital with which the doctor is connected. A further, and most important, service is that the hospital agrees to see clinic patients in the emergency room at times when the clinic is not open, either free or for the regular clinic fee of 25 cents. A social worker on the clinic staff investigates the financial status of the patients and assists them in contacting the Welfare Department or other public assistance that may be available. Special arrangements are made for non-resident patients as there are many migratory farm laborers in the area during the summer.

Patients are accepted at the clinic regardless of age, race, creed, color, national origin or length of residence. Financial need is judged with consideration not only for those receiving public assistance, but also for part-time workers and for full-time, unskilled workers with large families. Those who have been under the care of a private doctor are asked to bring a note of referral from him before they are accepted for clinic care.

* * *

FUNDS FOR THE operation of the clinic are contributed partly by the Saginaw Catholic Charities and partly by the United Fund. Although the new and greatly enlarged clinic will unquestionably involve a decided increase in the cost of operation, it is significant that the old Guadalupe Clinic has been caring for about 7000 patients a year at a cost of between five and six thousand dollars. Currently about 200 patients a week are being treated at the new clinic but the number is steadily increasing.

Genesee Diabetes Day Attendance Tops '62

More than 100 outstate doctors helped to run the Diabetes Day Program attendance at Flint to more than 250 physicians—topping the 1962 turnout.

The annual Genesee County Medical Society program featured speakers from Cleveland, Columbus, New York City, Iowa City, and also Columbia, Mo. The only Michigan doctor on the program was Jerome W. Conn, M.D., Ann Arbor, who discussed "The Differential Diagnosis of Spontaneous Hypoglycemia."

Clarify Draft Procedure

The National Advisory Committee to the Selective Service System has issued the following clarifying statement:

After a special call for physicians is received by the Director of Selective Service from the Secretary of Defense, the call is allocated by National Headquarters of Selective Service to the various states.

The distribution of the call to a state is determined by its percentage of the total number of physicians who have been classified as available for induction in the necessary number of age groups involved to meet the call. That is to say, if ten per cent of physicians in the age groups estimated to be needed to meet the call are to be found in your state then ten per cent of the call will be made against your state, i.e., if there are 1,000 in I-A (examined and acceptable) in the liable age group for that call in your state, they will be asked to supply 100 to meet the call.

OVER 80 YEARS'
SPECIALIZED EXPERIENCE
IN THE RESTORATIVE
TREATMENT OF

"THE PROBLEM DRINKER"

At The Keeley Institute your patients are assured of receiving:

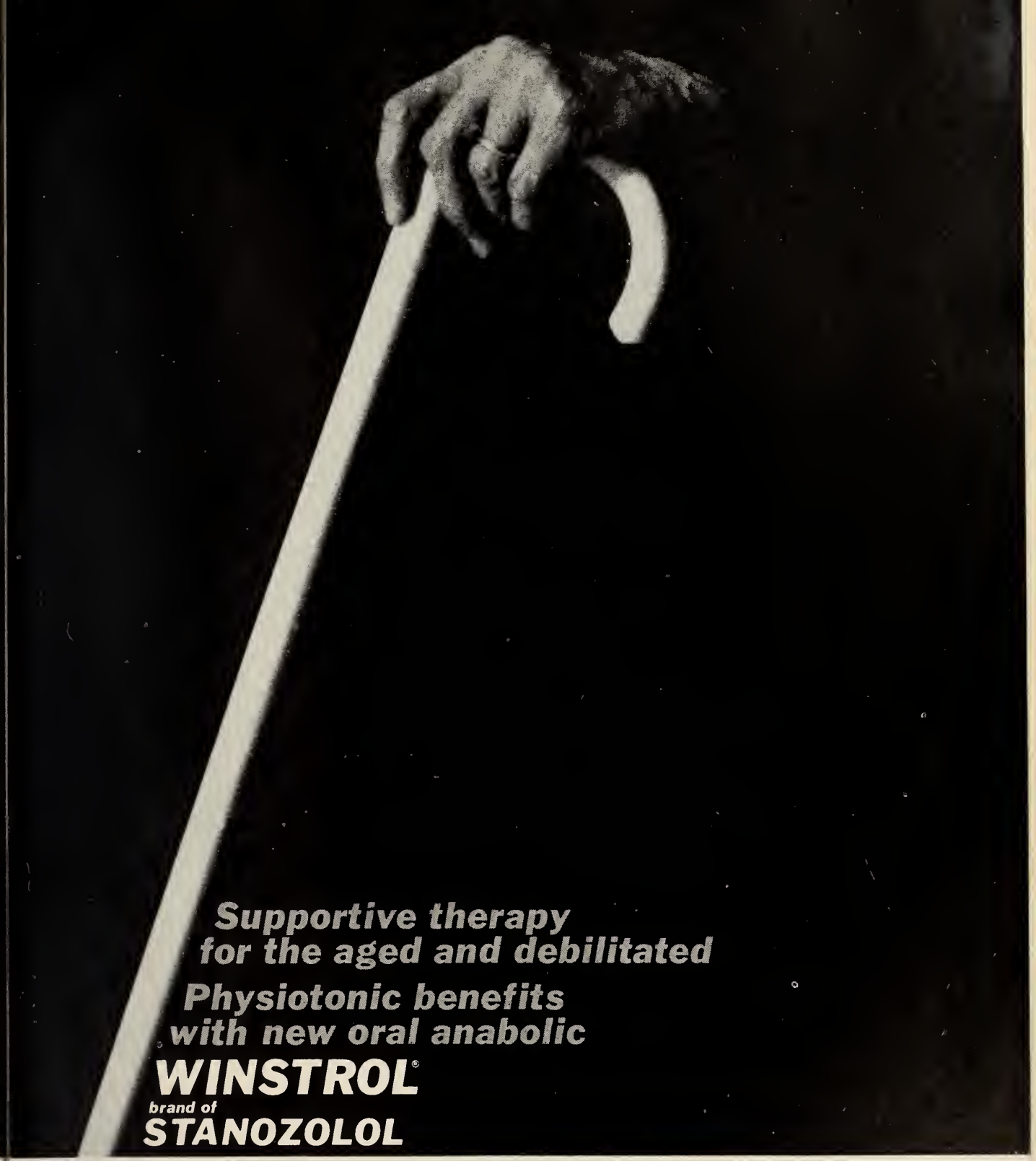
- the most modern, coordinated, comprehensive, rehabilitative regimen
- in addition to medical, nutritional and physiotherapeutic treatment, we also offer psychiatric diagnosis and psychotherapy
- full cooperation throughout with the referring physician
- surprisingly low cost—to cover all medical care, medicines, laboratory work, room and excellent cuisine

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Notable increase in vigor, strength and sense of well-being

TROL (stanozolol-Winthrop), a heterocyclic steroid, combines t anabolic effects with outstanding tolerance, stimulates appe- nd promotes weight gain... restores a positive metabolic balance. nteracts the catabolic effects of concomitant corticosteroid or l therapy. WINSTROL (stanozolol-Winthrop) rebuilds body tissue it builds strength, confidence and a sense of well-being in con- s associated with excess protein breakdown, insufficient protein e and inadequate nitrogen and mineral retention.

Effects and Precautions: Prolonged administration can produce hirsutism, acne or voice change. In an occasional patient, edema been observed and in young women the menstrual periods have milder and shorter. These side effects are reversible, and pa- receiving prolonged treatment should be examined and ques- tioned periodically so that, should side effects appear, the dosage may be reduced or administration of the drug discontinued for a time In patients with impaired cardiac and renal function, there is the pos sibility of sodium and water retention. Liver function tests may revea an increase in bromsulphalein retention, particularly in elderly pa tients. In such cases, therapy should be discontinued. Although it has been used in patients with cancer of the prostate, its mild androgenic activity is considered by some investigators to be a contraindication

Dosage: Usual adult dose, 1 tablet t.i.d. before or with meals; young women, 1 tablet b.i.d.; children (school age): up to 1 tablet t.i.d.; chil dren (pre-school age): ½ tablet b.i.d. Available as scored tablets of 2 mg. in bottles of 100. For best results, administer with a high protein diet.

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it's versatile: The years have proved that 'Miltown' (meprobamate) is the one tranquilizer that is helpful in almost every aspect of daily practice. Virtually any of your patients, regardless of age, can be given the drug with confidence, either as a primary treatment or as an adjunct to other therapy. **Outstanding record of safety:** Over eight years of clinical use among millions of patients throughout the world — plus more than 1500 published reports covering the use of the drug in almost every field of medicine — support your prescriptions for 'Miltown' (meprobamate). This is why it "*belongs in every practice.*"

dependable: 'Miltown' (meprobamate) is an established drug. There are no surprises in store for you or your patient. You can depend on it to help your patients through periods of emotional distress — and to help maintain their emotional stability.

easy to use: Because 'Miltown' (meprobamate) is compatible with almost any other kind of drug therapy, you'll find it fits in easily with any program of treatment you are now using. It will not, therefore, complicate treatment of patients seen in clinical practice.

BRIEF SUMMARY: *Indicotions:* Anxiety and tension states, and all conditions in which anxiety and tension are symptoms. *Side Effects:* Slight drowsiness may occur and, rarely, allergic or idiosyncratic reactions, generally developing after 1-4 doses of the drug. *Contro-indicotions:* Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. *Precoutions:* Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities, to patients with suicidal tendencies. Massive overdosage may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product informotion ovoiloble to physicians on request.*

USUAL ADULT DOSAGE: 1 or 2 400 mg. tablets t.i.d.

SUPPLIED: 400 mg. scored tablets, 200 mg. coated tablets.

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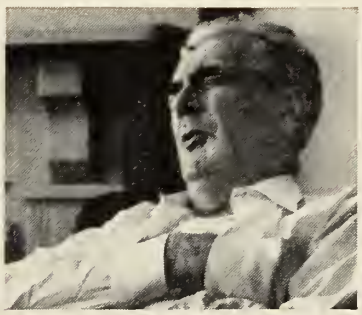
Say you saw it in the Journal of the Michigan State Medical Society



The insomniac



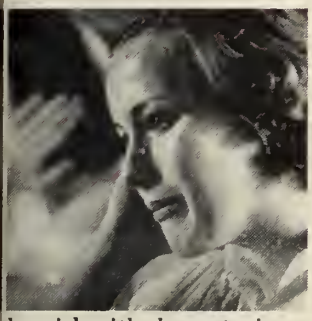
The tense, nervous patient



The heart-disease patient



The surgical patient



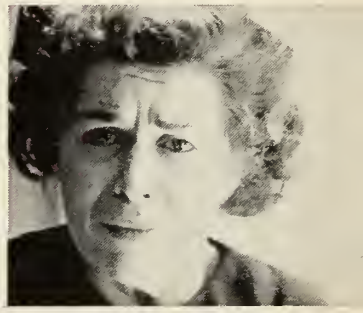
he girl with dermatosis



Tension headache



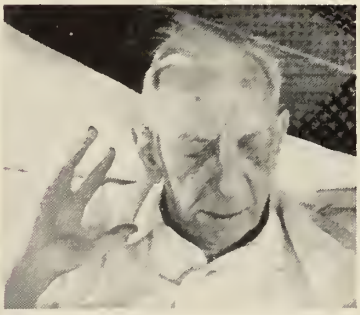
The woman in menopause



Anxious depression



Premenstrual tension



The agitated senile patient



The alcoholic



The problem child

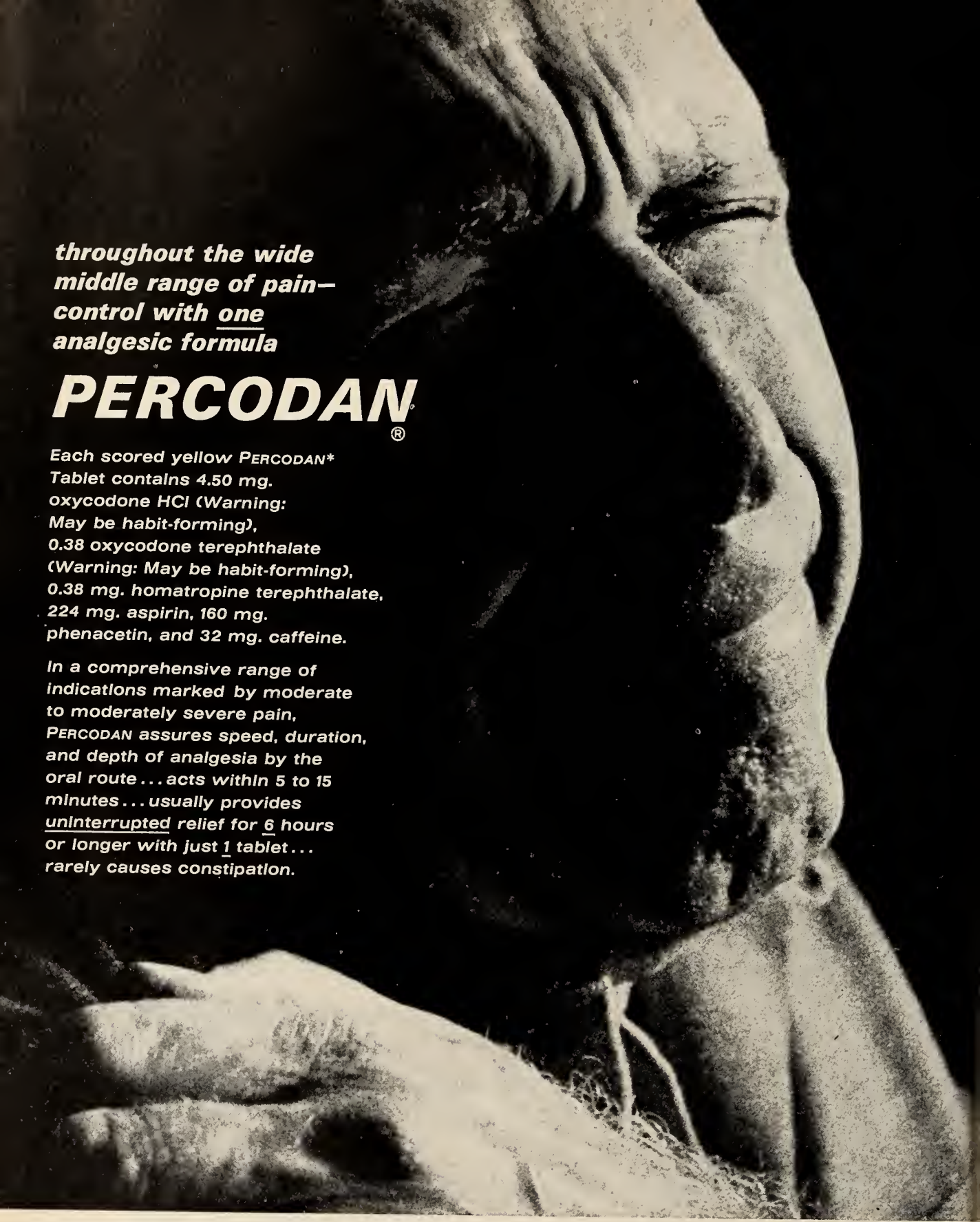
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Each scored yellow PERCODAN* *Tablet contains 4.50 mg. oxycodone HCl (Warning: May be habit-forming), 0.38 oxycodone terephthalate (Warning: May be habit-forming), 0.38 mg. homatropine terephthalate, 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.*

In a comprehensive range of indications marked by moderate to moderately severe pain, PERCODAN *assures speed, duration, and depth of analgesia by the oral route . . . acts within 5 to 15 minutes . . . usually provides uninterrupted relief for 6 hours or longer with just 1 tablet . . . rarely causes constipation.*

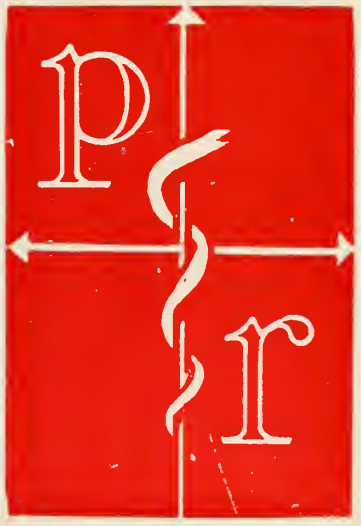
Average Adult Dose—1 tablet every 6 hours. **Precautions, Side Effects and Contraindications**—The habit-forming potentialities of Percodan are somewhat less than those of morphine and somewhat greater than those of codeine. The usual precautions should be observed as with other opiate analgesics. Although generally well tolerated, Percodan may cause nausea, emesis, or constipation in some patients. Percodan should be used with caution in patients with known idiosyncrasies to aspirin or phenacetin, and in those with blood dyscrasias. **Also available:** Percodan®-Demi, containing the complete Percodan formula but with only half the amount of salts of oxycodone and homatropine. Both products are on oral Rx in all states where laws permit. Narcotic order required. **Literature on request.** **ENDO LABORATORIES Richmond Hill 18, New York**

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*U. S. Pats. 2,628,185 and 2,907,768

Materials Provided High School Debaters

By Ralph T. Wills
Director, Community Relations



Across the state (and nation), high school students are today debating the question:

> "Resolved, that the Federal Government should provide essential medical care for all citizens at public expense."

To provide information for these young people, the Michigan State Medical Society has distributed more than 400 comprehensive kits of material supporting medicine's view to Michigan high schools with debating teams. Hundreds of individual student requests for kits also have been filled—and additional kits still are available.

Typical of several preparatory area meetings held throughout Michigan was one in Flint sponsored by the Flint Junior College where over 450 debate team students and their coaches heard the views of experts.

Ten panelists hammered out the pros and cons. There was no judge to declare the winners.

The purpose of the day-long clinic was to give debaters, who came from throughout the State, background and better insight into the issues of their topic for the year.

Summations of the arguments presented at Flint are as follows:

Alvin M. Bentley, Owosso, former U. S. Congressman: Federal government already plays an active role in the health of the country, spending about $5 billion this year. Medical care goes beyond these "legitimate" expenditures into the area of socialized medicine. Some program must be found to provide necessary care for older citizens, but it should not be financed through increases in the Social Security tax.

Zolton A. Ferency, Lansing, Chairman of the Democratic State Central Committee: Health is different from the automotive or storm-window business which operates on competition and profit. The traditional American business is operated on this basis. But should there be competition and profit in health? Opponents attack government proposals with "scare" words such as "galloping socialism or creeping communism," to give the idea that it is "un-American."

Theodore Goldberg, Detroit, program consultant of the United Auto Workers Social Security department: The only way to assure high quality care for everyone is through a federal program. Disease is more common among the poor, who least can afford the cost of treatment.

A federal program would spread the risk of illness over a greater number and shift the responsibility for the cost of those better able to pay. The system of financing is used now. The bulk of welfare costs

(Continued on Page 1172)

Greenfield Village Adds Country Doctor's Office

The dedication ceremony for the Early American Doctor's office at Greenfield Village included a short address by William J. Stapleton, Jr., M.D., MSMS Historian. Following is his short speech:

The Art of Medicine

THE DOCTOR

There are men and classes of men that stand above the common herd: the soldier, the sailor, the shepherd not unfrequently; the artist rarely; rarelier still, the clergyman; the physician almost as a rule. He is the flower (such as it is) of our civilization.

R. L. STEVENSON, Underwoods: Dedication

Such a man was the doctor whom we honor today—Doctor Alonson Bingley Howard.

The letters addressed to me regarding this dedication program asked me to speak for five or ten minutes on "The Contribution of the Pioneer Country Doctor to the Progress of Medicine." I could tell you of Ephraim MacDowell and his operation for the removal of a large ovarian tumor done in his office—or of Marion Sims, the plantation doctor who took care of the slaves—who discovered the use of ergot, did the first successful operation for vesico-vaginal fistula—Sims speculum, et cetera. However, time does not permit elaboration on these themes. We shall speak specifically about the country doctor.

In the office of Doctor Howard were found barrels of Wahoo and Skunk Cabbage, apparently much used by the doctor in his practice. Through my friend, Dr. Harvey Merker, formerly of Parke, Davis & Company, I found that Wahoo was classified as a laxative. In a catalog of that company for the year 1868, I also learned that Skunk Cabbage was used as a stimulant and anti-spasmodic. We could talk about the medicines used by the country doctor which today are not even listed in our materia medica.

In the few minutes allotted to me, I would like to talk, not about the medicines used by the country doctor but about what I consider his greatest contribution to medicine. It was the *art of medicine.* Why have so many people recently turned against the medical profession? Why are we being criticized and what can we do to stop this rise in public criticism? I don't think it is due to the rising cost of medical care, because all of us know that the cost of living has risen and that this is with us each day of our lives.

What about the old family doctor? He left the medical school trained in the knowledge of his day—



Authorities in modern day medicine were part of an extensive dedication ceremony at Greenfield Village October 15, as Howard D. Washburn (foreground) presented an Early American doctor's office to the Village. The building, formerly used by Washburn's great grandfather, Alonson B. Howard, M.D., was transplanted from Tekonsha to join the 100 other historic structures representing more than 300 years of American history. Doctor Howard practiced from this clapboard structure from the 1850's until his death in 1883. The building was then sealed, remaining unopened for 70 years, until work began transplanting it to Greenfield Village. The doctor gained extensive knowledge of root and herb medicine from friendly Indians, in the semi-frontier country around Marshall and used this basic knowledge, along with formal training from two medical schools. Picturesque kegs, jugs and bottles, labeled "wild snakeroot," "extract of wahoo," and other such names are all part of the building which may be seen daily all year round at Greenfield Village. From left to right, at the dedication, are Luther R. Leader, M.D., Birmingham, AMA representative; Oliver B. McGillicuddy, M.D., MSMS President-Elect; Charles J. Tupper, M.D., associate dean, Medical Schools, University of Michigan; Donald A. Shelley, executive director, Henry Ford Museum and Greenfield Village; William J. Stapleton, Jr., M.D., MSMS Historian, and R. J. Campbell, M.D., president, Calhoun County Medical Society.

but beside that, he had a keen interest in the patient as a combination of body and soul. He made up his lack of our present day aids to diagnosis with a great possession—the art of medicine. Each patient was treated with kindness, with tact, understanding, patience and undivided attention. There was no doubt in the patient's mind that the doctor was thinking not only of the patient's present sickness, but also of its effect on his entire body, on his life, and even on his soul. He spent much time at the patient's bedside. In

(Continued on Page 1172)

2 new works of timely interest

READY JANUARY FROM SAUNDERS

A New Book! ATOMIC ENERGY ENCYCLOPEDIA IN THE LIFE SCIENCES

Edited by C. W. Shilling

Covers Applications and Effects of Atomic Energy in the Fields of Medicine, Biology, and Agriculture. Every Item Verified by Experts of the U.S. Atomic Energy Comm.

This is the information you'll find in this authoritative new information source: the effects of atomic radiation on living material; the uses of radiation and radioisotopes in medicine, agriculture and biology; scores of other peaceful uses of atomic energy. Topics range from treatment of cardiac disease with radioactive isotope iodine-131 to methods of radioactive waste disposal. More than 1200 alphabetically-arranged entries give you precise information on topics with wide application to clinical practice and research as well as on topics of general, scientific, educational and historic interest.

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Editor and Major Contributor, CHARLES WESLEY SHILLING, M.D., D.Sc., Consultant to the United States Atomic Energy Commission; Deputy Director, Division of Biology and Medicine, USAEC, 1955-60. With the Assistance of MIRIAM TEED SHILLING, M.A. Prepared under the auspices of the Division of Technical Information, USAEC. 474 pages, 7¼" x 10¼", with 268 illustrations, 98 tables. About $10.50. *New—Ready January!*

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(Continued from Page 1170)

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* * *

Doctor Stapleton added: "We are indebted to the editorial in the *Rocky Mountain Medical Journal* for April 1963 by Harry W. Frank, M.D., for help in preparing this article."

Medical Self-Help Exhibit Available from State

An exhibit to help promote the Medical Self-Help Program recommended to every component society by the MSMS House of Delegates is available from the Michigan Department of Health. Requests should be sent directly to the Michigan Department of Health, Division of Local Health Administration, Lansing.

MSMS in the News!

Association executives across the nation have been told the story of the 1963 MSMS Annual Session emphasis on panel discussions—thanks to the national publication, *Association Newsletter.*

In a recent edition, the editor, George K. Dahl, pointed out that the 1963 Annual Session "featured panels rather than the former pattern of didactic lectures." The publication also stressed that the MSMS meeting provided ample intermissions to permit the doctors to inspect the exhibits.

Materials Provided High School Debaters

(Continued from Page 1169)

are borne by the rich who use welfare services the least.

John B. Rowe, M.D., president of the Genesee County Medical Society: Any program where the "great white father supplies everything" destroys individual initiative.

Chester Tossey, D.D.S., Lansing, director of the dental division of the Michigan State Department of Health: The federal government should step in only after all sources of help have been exhausted.

Bennett J. McCarthy, Detroit, assistant general manager of Michigan Hospital Service (Blue Cross): Federal government should not be involved in medical-hospital care of the citizens. A national program, to work, would include federal ownership of hospitals and facilities and payment of salaries to physicians. This would tremendously increase costs and result in the deterioration of services.

John Panchuk, Battle Creek, secretary and general counsel of the Federal Life & Casualty Co.: The issue is government monopoly versus voluntary insurance. The voluntary methods have achieved tremendous gains and are covering the gaps. Government monopoly would require an organized society and standardized methods of care and treatment.

Don E. Ranney, D.O., Farmington, MAOPS: The reasons for the problem coming into focus now are many, but include the fact that there has been an increase in the number of aged, largely through improved levels of health care. No citizen should be denied adequate health care. Programs now before Congress do not provide for first-class medical care.

Philip Longley, M.D., Cleveland physician representing the American Medical Association: A federal program would be undesirable. It would destroy the best system of medical care in the world by tying it up in red tape and placing it in the hands of bureaucrats. "I know of no documented case where a person has been denied medical care when he needed it."

Myron S. Magen, D.O., Trenton, representing the Michigan Association of Osteopathic Physicians and Surgeons (MAOPS): The primary purpose of all health care is to provide the highest level of health to the people, and no other consideration should be permitted to interfere. We support the thesis that government might share in the cost of health care for special segments of the population so long as it is done within the framework of our traditional free enterprise system.



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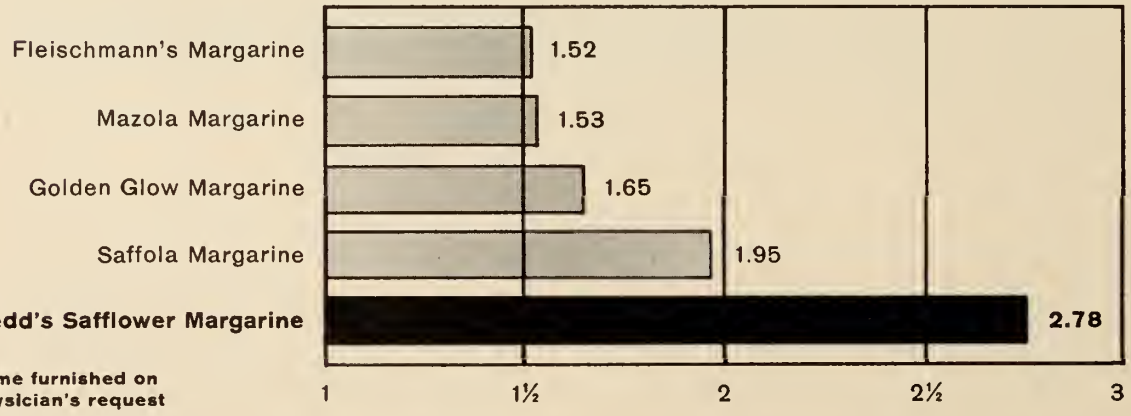


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Economic Profiles of Michigan Communities

Eli P. Cox, Director of the Bureau of Business and Economic Research of Michigan State University, has just completed a study which describes an economic profile of ten selected metropolitan areas in Michigan, comprising 14 counties.

The Detroit metropolitan area is composed of Wayne, Oakland and Macomb counties; the Lansing metropolitan area is made up of Ingham, Clinton and Eaton counties; the remaining areas—Ann Arbor, Bay City, Flint, Grand Rapids, Jackson, Kalamazoo, Muskegon and Saginaw—are made up of single counties.

Changes in various economic characteristics as developed by the Cox study from United States Census figures, are shown in the following tables.

Population Changes, 1950-1960

Area	*% Increase*
Ann Arbor	28
Bay City	21
Detroit	25
Flint	38
Grand Rapids	26
Jackson	22
Kalamazoo	34
Lansing	22
Muskegon	23
Saginaw	24

Flint, Kalamazoo and Ann Arbor did considerably better than the metropolitan average of 25.6%. Flint was the highest with an increase of 38%, while Bay City was the lowest with 21%.

Changes in Total Employment, 1950-1960

Area	*% Increase*
Ann Arbor	36
Bay City	16
Detroit	11
Flint	22
Grand Rapids	16
Jackson	20
Kalamazoo	27
Lansing	21
Muskegon	23
Saginaw	13

Ann Arbor and Kalamazoo led the way with increases of 36% and 27%, respectively. Detroit and Saginaw fell between the general metropolitan average of 14.6%.

Materials for the Medical Socio-Economic Section of THE JOURNAL are provided by Richard M. Campau, MSMS Research Director.

Changes in Manufacturing Employment, 1950-1960

Area	*% Increase*
Ann Arbor	20
Bay City	22
Detroit	minus 3
Flint	11
Grand Rapids	6
Jackson	20
Kalamazoo	23
Lansing	4
Muskegon	18
Saginaw	9

Four metropolitan areas, Kalamazoo, Bay City, Jackson and Ann Arbor, had gains of 20 per cent or better between 1950 and 1960. This compares with a loss of 3 per cent by Detroit, relatively small gains by Lansing and Grand Rapids, and somewhat larger ones by the remaining areas.

Changes in Durable Goods Manufacturing Employment, 1950-1960

Area	*% Increase*
Ann Arbor	16
Bay City	23
Detroit	minus 8
Flint	9
Grand Rapids	5
Jackson	22
Kalamazoo	26
Lansing	0
Muskegon	14
Saginaw	5

Detroit was the only loser of durable goods manufacturing employment with a decrease of 8 per cent from 1950 to 1960. Lansing held its own during this period with the remaining areas showing gains ranging from Saginaw and Grand Rapids at 5 per cent to 26 per cent for Kalamazoo.

Changes in Non-Durable Goods Manufacturing Employment, 1950-1960

Area	*% Increase*
Ann Arbor	47
Bay City	20
Detroit	30
Flint	59
Grand Rapids	14
Jackson	25
Kalamazoo	22
Lansing	34
Muskegon	65
Saginaw	37

Although percentage increases in this category are dramatic, and averaged about 30 per cent for the ten areas, the actual increase in non-durables manufacturing employment only amounted to about 33,000. Durable goods manufacturing still dominates Michigan's

metropolitan areas and provides nearly five times as many jobs as does non-durable manufacturing, despite large percentage gains in the latter.

Changes in Non-Manufacturing Employment, 1950-1960

Area	*% Increase*
Ann Arbor	42
Bay City	11
Detroit	24
Flint	36
Grand Rapids	22
Jackson	19
Kalamazoo	30
Lansing	29
Muskegon	27
Saginaw	16

The average increase was about 25 per cent, ranging from Bay City's low of 11 per cent to Ann Arbor's high of 42 per cent. Non-manufacturing employers were providing almost a quarter of a million more jobs in 1960 than in 1950.

Changes in Median Family Income, 1950-1960

Area	*% Increase*
Ann Arbor	101
Bay City	81
Detroit	72
Flint	63
Grand Rapids	76
Jackson	89
Kalamazoo	81
Lansing	73
Muskegon	90
Saginaw	76

Dramatic changes took place in median family incomes of those areas studied. The lowest was Flint where median family income rose from $3,897 to $6,340 (63%) and the highest was Ann Arbor where it increased from $3,435 to $6,890 (101%).

Scope of Health Insurance Zooms in Past Decade

Health insurance protection against the cost of doctor calls and other nonsurgical care by doctors has grown from 35,670,000 persons insured at the end of 1952 to 98,204,000 persons insured at the end of 1962.

The Health Insurance Institute reports growth of this coverage is one measure of how the American people have materially broadened their health insurance protection over the past ten years.

At the end of 1952, more than 91 million Americans had hospital expense coverage, indicating that approximately four out of every ten persons with hospital insurance also had regular medical insurance.

At the end of 1962, more than 141 million persons had hospital insurance, so that nearly seven out of every ten persons with hospital insurance now have regular medical insurance, said the Institute.

Coverage under regular medical expense insurance can be expected to continue to grow, the Institute said. It is estimated that at the end of June 1963 some 100 million persons had this coverage.

Michigan Information about Population and Employment by Counties

The following statistics will be of interest to doctors of medicine because they have a direct bearing upon their practice. These were recently released by the Michigan Economic Development Department from the 1960 United States Census:

AREA (State, Counties)	Population	Per cent Rural Farm	Per cent of Employed Manufacturing	Per cent of Employed White Collar Occupations[2]	Median Income of Families
STATE	7,824,965	5.6	38.0	40.1	$6,256
COUNTIES					
Alcona	6,352	28.3	16.7	33.9	4,167
Alger	9,250	10.2	35.3	33.4	5,028
Allegan	57,729	21.8	39.7	28.7	5,532
Alpena	28,556	12.3	37.9	35.6	5,575
Antrim	10,373	19.3	30.3	29.7	4,002
Arenac	9,860	28.0	23.5	30.7	4,237
Baraga	7,151	11.8	19.9	33.6	4,287
Barry	31,738	21.7	39.9	30.5	5,592
Bay	107,042	9.5	40.8	37.0	6,041
Benzie	7,834	13.0	20.3	32.9	4,563
Berrien	149,865	9.8	42.4	36.1	6,145
Branch	34,903	21.9	29.5	29.6	5,449
Calhoun	138,858	6.6	36.4	38.6	6,376
Cass	36,932	18.1	40.3	29.3	5,418
Charlevoix	13,421	15.2	27.0	33.5	4,502
Cheboygan	14,450	12.2	16.7	39.0	4,291

AREA (Counties)	Population	Per cent Rural Farm	Per cent of Employed Manufacturing	Per cent of Employed White Collar occupations[2]	Median Income of Families
Chippewa	32,655	8.3	10.4	41.2	4,975
Clare	11,647	13.9	30.1	32.0	4,400
Clinton	37,969	27.8	31.4	30.0	5,636
Crawford	4,971	0.4	25.6	37.7	4,399
Delta	34,298	7.4	28.1	37.8	5 009
Dickinson	23,917	3.3	27.2	39.1	4,770
Eaton	49,684	21.0	33.6	34.8	5,821
Emmet	15,904	47.2	13.2	42 0	4.694
Genesee	374,313	2.3	50.7	33.4	6,340
Gladwin	10,769	31.3	26.7	32.9	4,431
Gogebic	24,370	2.1	15.1	33.1	4,237
Grand Traverse	33,490	9.6	19.0	43.2	5 259
Gratiot	37,012	28.9	31.4	34.4	5,218
Hillsdale	34,742	29.4	31.8	27.8	4,940
Houghton	35,654	5.6	11.8	37.1	4 260
Huron	34,006	38.7	17.9	28.7	4 193
Ingham	211,296	4.1	24.5	49.4	6 393
Ionia	43,132	21.9	38.9	28.8	5,091
Iosco	16,505	8.7	17.1	40.7	4,602
Iron	17,184	5.5	5.5	33.1	5,043
Isabella	35,348	21.5	19.1	37.2	5,206
Jackson	131,994	6.4	35.5	39.6	6,421
Kalamazoo	169,712	4.1	38.4	42 7	6,526
Kalkaska	4,382	19.5	29.5	36.4	3,876
Kent	363,187	3.3	36.2	43.3	6 329
Keweenaw	2,417	0.5	8.3	21.1	3,952
Lake	5,338	14.2	18.6	30 7	3,153
Lapeer	41,926	24.7	31.0	27.4	5 282
Leelanau	9,321	28.7	17.2	33.6	4 139
Lenawee	77,789	17.2	40.4	33.6	5,699
Livingston	38,233	15.2	31.7	35.3	5,775
Luce	7,827	2.1	11.5	35.0	5 254
Mackinac	10,853	7.2	8.1	37.5	4,721
Macomb	407,178	1.7	46.6	41.2	7,091
Manistee	19,042	10.4	37.0	33.0	5,112
Marquette	56,154	1.5	14.3	36.4	5,022
Mason	21,929	17.7	29.4	31.8	4,991
Mecosta	21,051	22.0	21.3	40.1	4,322
Menominee	24,685	15.8	36.7	32.4	4,323
Midland	51,450	8.9	51.9	45.0	6,627
Missaukee	6,784	38.4	18.8	27.7	3 673
Monroe	101,120	11.2	43.1	31.8	5.892
Montcalm	35,795	24.7	33.1	29 5	4,815
Montmorency	4,424	25.5	18.9	35.0	3 574
Muskegon	149,943	2.3	48.8	36.1	6,048
Newaygo	24,160	21.2	35.5	32.7	4,583
Oakland	690,656	0.7	41.2	49.4	7,576
Oceana	16,547	28.1	33.8	27.5	4,841
Ogemaw	9,680	25.6	21.5	31.7	3,874
Ontonagon	10,584	14.9	14.8	27.7	4,736
Osceola	13,595	27.7	30.8	26.0	4,350
Oscoda	3,447	19.3	15.7	41.2	4,442
Otsego	7,545	13.7	23.9	34.0	4,556
Ottawa	98,719	10.8	42.5	33.9	5,920
Presque Isle	13,117	21.2	11.4	30.2	5,140
Roscommon	7,200	3.5	11.4	47.5	4,477
Saginaw	190,752	7.4	40.0	37.7	5.983
St. Clair	107,201	9.0	33.0	36.8	5,546
St. Joseph	42,332	15.4	42.4	29.5	5,626
Sanilac	32,314	44.3	25.3	24.3	4,428
Schoocraft	8,953	6.1	19.8	33.3	4,438
Shiawassee	53,446	17.4	40.7	33.2	5,740
Tuscola	43,505	30.2	29.3	28.0	4,993
Van Buren	48,395	21.6	34.0	28.6	5,196
Washtenaw	172,440	5.3	23.3	50.5	6,890
Wayne	2,666,297	0.1	39.8	41.8	6,597
Wexford	18,466	8.1	29.9	39.3	4,865



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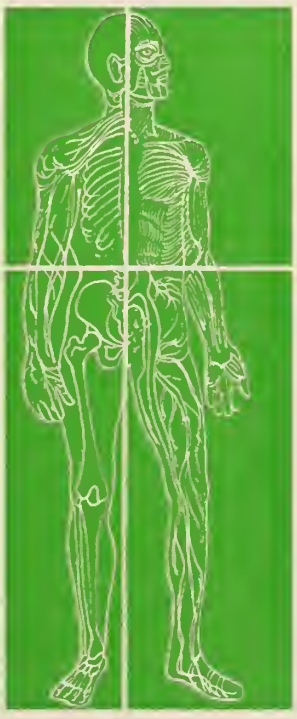
Treatment of Pituitary Tumors

Analysis of 100 Cases

Hugh A. Clarke, M.D.
Robert S. Knighton, M.D.
José Bebin, M.D.
Detroit, Michigan

In the present state of our knowledge, surgery admittedly constitutes our chief source of defense against advances of the large number of recognizable pituitary maladies.

HARVEY CUSHING, 1912[1]



THE TREATMENT of pituitary tumors in the last 50 years has remained controversial, and the different approaches to the solution of this problem have varied with the emphasis on either partial surgical removal or various forms of irradiation. In the early 1900's the surgical approach was the treatment of choice, as the statement of Cushing exemplifies. The progress in radiotherapeutic technics in the last two decades has somewhat modified this statement; however, surgery of pituitary tumors remains one of the most successful ways to treat these conditions.

Following Pierre Marie's discovery in 1886 that acromegaly was due to a pituitary tumor, many classics have been written regarding the histology and pathology of the pituitary gland.[2] Flesch (1884) and Dostojewski (1886) described two types of cells in the anterior lobe (chromophobe and chromophile). Schönemann (1892) further divided the chromophile cells into basophile and eosinophile. Benda (1900), combining previous studies, related these cells to pituitary tumors.[3-6]

Twenty-five years later, the first complete clinicopathological discussion of pituitary tumors, using Cushing's cases, was presented by Dott and Bailey (1925).[7]

The first surgery for a pituitary tumor was attempted by Sir Victor Horsley in 1889.[8] A temporal approach was made, but the tumor was thought to be inoperable. In the early 1900's, Schloffer (1907) successfully removed a pituitary tumor transnasally.[9] Two years later, Hirsch described his transphenoidal approach.[10] Cushing used this approach on his first 43 cases, but abandoned the procedure 10 years later in favor of the transfrontal approach (Frazier) which, with some modification, has remained the procedure of choice in most neurosurgical centers.[11]

Radiation therapy as a treatment for pituitary tumors was first attempted by Béclère (1909).[12] Four years later, Heinismann and Czerny (1913) were able to accumulate 73 cases from the literature, and presented 15 of their own cases which had received irradiation. It was their impression that the acromegalics received more benefit

From the Division of Neurological Surgery, Henry Ford Hospital, Detroit 2, Michigan.

than did those patients with chromophobe adenomata.[13] Henderson (1939), analyzing Cushing's series, presented evidence that patients receiving irradiation following surgery had a better prognosis than those having surgery alone.[14] Horrax, using supervoltage irradiation, was able to deliver 4000r directed at the pituitary fossa. This accomplishment is an important event in the tretament of pituitary tumors.

During the last decade, many series of pituitary tumors have been presented (Bakay, 1950; Younghusband et al, 1952; Wise et al, 1955; Kernohan and Sayre, 1956; Jefferson, 1957; Ray, 1960; Poppen, 1963). The two main forms of treatment (surgery and irradiation) have been explained, and the merits of each emphasized.[15-22]

All authors agree that the primary aim of both modes of treatment is to preserve visual efficiency, possibly reverse the loss of visual acuity and constriction of the visual fields, and to arrest or modify the glandular dysfunction produced by some of these tumors.

This series of cases represents the experience at this institution in the treatment of pituitary tumors in the past 20 years. Approximately 280 persons have been examined with symptoms and signs suggestive of a pituitary tumor. For the purpose of this discussion, only those cases which have manifested definite objective signs, such as enlargement or destruction of the sella turcica, with or without evidence of pituitary dysfunction or visual disturbances, have been included.

One hundred patients with pituitary tumors are presented. These cases are divided into two groups. The first group includes those patients with clinical findings commensurate with the diagnosis of chromophobe adenoma, including two cases which at surgery were proven to be mixed tumors and another two cases of pituitary carcinoma. The second group includes those with clinical acromegaly, which have also shown enlargement and/or destruction of the sella turcica.

The diagnosis of a pituitary tumor is not difficult. The history of headache, amenorrhea or loss of libido, and the general appearance of both the chromophobe patient, with a hypofunctioning gland, and the acromegalic patient are quite characteristic. Further verification is made by x-ray of the skull, which shows the characteristic ballooning of the sella turcica with a double contoured base and thinned but still intact posterior clinoid processes. With large tumors there may be apparent erosion through the posterior wall of the sphenoid sinus and destruction of the posterior clinoid processes.

Determination of visual fields and visual acuity gives further information regarding extra-sellar extension of the tumor. The characteristic field defect is an asymmetrical bitemporal hemianopsia. The defect progress-

TABLE I. CLINICAL MANIFESTATIONS

	Chromophobe Adenomata (75)			Acromegalics (25)		
Average age	47.8 yrs. (16-71)			45 yrs. (21-73)		
Sex distribution	47 M (62.6%) 28 F (37.3%)			12 M (48%) 13 F (52%)		
Central nervous system	*per cent*			*per cent*		
Headache	25	(33.3)		12	(48)	
Visual	21	(38.0)		1	(4)	
Visual field defect	65	(81.0)		2	(8)	
Visual acuity[1]	38	(50.6)		4	(15)	
Unilateral blindness	8	(10.6)			(—)	
Bilateral blindness	10	(13.0)		1	(4)	
Optic atrophy	37	(49.3)		1	(4)	
Headache and visual disturbance	15	(20.0)		1	(4)	
Seizures	2	(2.6)		1	(4)	
Hemiplegia	3	(4.0)				
Associated neurological disease	1	(1.3)				
Endocrine						
Oligo-and/or amenorrhea	12	(42.8)		8	(32)	
Impotence	22	(29.3)		6	(24)	
Libido increased	1	(1.3)		2	(8)	
Lactation	4	(5.3)			—	
	(2M 2F)					
Hypopituitarism	*pre-Rx*		*post-Rx*	*pre-Rx*		*post-Rx*
	17	(22.0)	27 (36%)			1 (4%)
Hypertension[2]	18	(24.0)	N.S.C.	10	(40)	N.S.C.
Hypotension[3]	7	(9.3)	N.S.C.	—	(—)	—
Hyperglycemia[4]	13	(17.3)	N.S.C.	8	(32)	N.S.C.

[1] Visual acuity decreased more than 10%.
[2] Blood pressure greater than 140/90 mm.Hg.
[3] Persistent systolic pressure less than 90 mm.Hg.
[4] Elevated postprandial glycemia or diabetic type of glucose tolerance curve.
N.S.C.=No significant change.

es from the superior temporal quadrants in a predictable manner as the chiasm is further compromised. With lateral extension of the tumor, the hemianopsia may be homonymous rather than bitemporal. The first changes in visual efficiency are produced by direct pressure against the chiasm; but as the nerves are thinned from long-standing pressure and stretching, vascular and glial changes occur which lead to progressive and often irreversible loss of visual acuity, optic atrophy and ultimate blindness. Any form of therapy should be directed toward the prevention of this catastrophe.

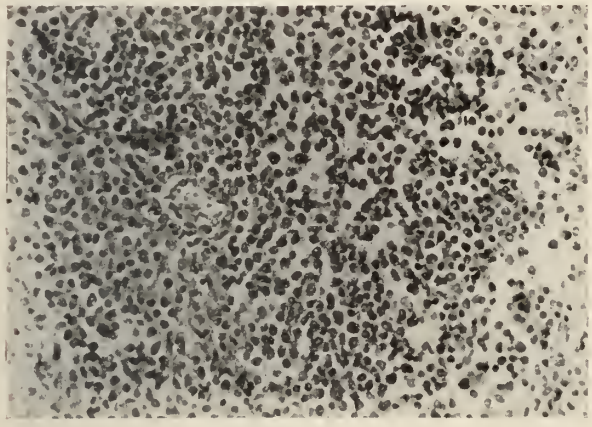


Fig. 1. Case of carcinoma of the pituitary gland. Note anaplasia and diffuse arrangement of tumor cells. (x16)

Pituitary function, through its effect upon target organs, may be investigated by various methods. These studies are usually outlined by consulting internists or endocrinologists and generally require three days for the average patient.

Growth hormone may be estimated by a hemagglutination-inhibition reaction. The availability of this test is limited at present (Kaplan, '62).[23] Therefore, less specific tests (serum phosphorus, glucose and insulin tolerance) must serve to indicate growth hormone levels. Typhoid function is usually measured by the PBI content in blood. An iodine^{131} uptake, less discriminating, may be occasionally used. The B.M.R. is not recommended if the aforementioned, more specific assessments can be made. Two 24-hour urine specimens are obtained for determination of creatinine, gonadotropins, 17-ketosteroids (♀ 8-15 mg., ♂ 11-19 mg./day) and 17-hydroxysteroids (5-15 mg./day). The same specimen may be used for estimating creatine excretion ($<$ 150 mg./day) in acromegalic patients. Two plasma specimens are drawn for 17-hydroxysteroids (8-9 A.M., 3-4 P.M.) (10-25 micrograms) to evaluate the diurnal change in adrenocortical secretion.

Examination of testes, prostate, and vaginal smears may also give further information regarding gonadal function. ACTH activity is measured by two methods: the SU-4885 test and the previously mentioned estimations of steroids in the plasma and urine. SU-4885 is



Fig. 2. Chromophobe adenoma of the pituitary gland. Characteristic ballooned sella turcica with a double-contoured base and thinned but still intact posterior clinoid processes.

an amphenone derivative which blocks 11-beta-hydroxylase activity and prevents the production of hydrocortisone. More ACTH is produced, thus causing an increase in secretion of "non-blocked" compound S. Patients with a normal pituitary gland exhibit an increase in urinary (11-desoxy-17-hydroxy) corticosteroids (Danowski, '62).[24] The ability to concentrate urine is an estimation of the integrity of the supraopticohypophyseal tract and the neurohypophysis.

Endocrinologists are of the opinion that in hypopituitarism due to tumor gonadotropin secretion is the first to be depressed, followed by TSH and ACTH deficiency. It is of interest that cholesterol is normal or low in "pituitary hypothyroidism" (Ross, '61).[25]

In addition to the tests outlined, blood sugar (2 hr. p.c. or complete glucose tolerance) and calcium-phosphorus determinations are made in all cases of pituitary tumors. An elevated serum inorganic phosphorus in the absence of uremia is indicative of active acromegaly (Ross, '61).[25]

If the visual fields and acuity are compromised, more specific studies are performed. In our opinion, a fractional pneumoencephalogram (with or without laminography) gives the most information. Carotid angiography is useful to exclude a possible aneurysm, and more recently Mercury^{203} brain scans have been useful in delineating the extent of the tumor.

There were 75 patients with chromophobe adenoma. The average age of the patients with a chromophobe tumor was 47.8 years, with a large age spread, how-

ever, of 16 to 71 years. For the acromegalic, the average age was essentially the same at 45 years, and again with a large age spread of 21 to 73 years. In the chromophobe group, the males outnumbered females approximately 2 to 1; and in the acromegalic

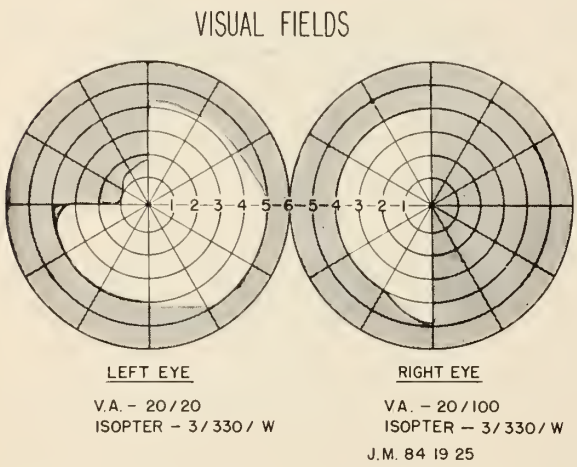


Fig. 3. Typical decrease in visual efficiency observed in a case of pituitary chromophobe adenoma.

group, the distribution was about equal, although in other series females often outnumbered males (Davidoff, 1948; Kellgren, 1952; Balzer, 1958).[26-28]

The presenting symptoms were essentially the same in both groups and included headache, which is often more severe in the eosinophilic adenoma, visual disturbance, amenorrhea or oligomenorrhea, impotence, and interestingly enough, increased libido in one case of chromophobe adenoma. Lactation was also an interesting phenomenon in four of our patients with chromophobe adenoma, two of whom were males. This disturbing symptom was not affected by treatment. Often amenorrhea was a very early symptom, preceding other symptoms by many years.

Objective visual loss was carefully studied, and here there was considerable difference between the chromophobe and the acromegalic patients. In the chromophobe group, 81 per cent had some alteration of the visual fields and over 50 per cent had a greater than 10 per cent loss in visual acuity, as contrasted with about 15 per cent of the patients with acromegaly. Unilateral and bilateral blindness and optic atrophy were present in a considerable number of patients. Only 17 patients (22 per cent of the chromophobe adenomata) showed objective evidence of diminished pituitary function before treatment. Twenty-seven of the patients had objective evidence of hypopituitarism following treatment, and one eosinophile adenoma in whom a total hypophysectomy was performed had hypopituitarism postoperatively. Of considerable interest is the fact that 18 (24 per cent of our chromophobe patients) had hypertension; this percentage is about the same as reported in Olivecrona's series (Bakay, 1950). Only seven (9.3 per cent) had hypotension before treatment, and no significant change was noted in either of these groups following treatment. Again of interest was the hyperglycemia noted in 13 (17 per cent) of the chromophobe tumors; this

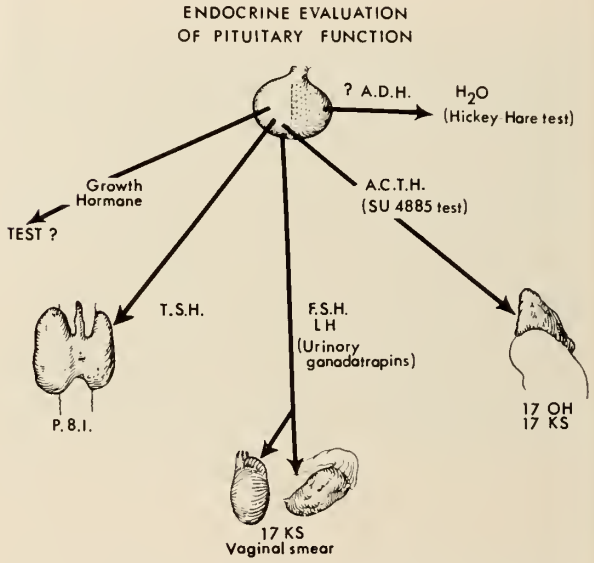


Fig. 4. Proposed endocrine evaluation in all suspected cases of pituitary tumor.

is usually considered a more likely phenomenon in the eosinophile tumors. Actually, two of our acromegalic patients had mixed adenomata rather than eosinophilic adenomata, and a clearcut relationship is not always present between the tumor type and the clinical syndrome. There was no significant improvement in the hyperglycemia after treatment. In the series of surgically treated cases of acromegaly reported by Bronson Ray (1962), in which total hypophysectomy was performed, there was a significant improvement in five patients who had preoperatively suffered from severe diabetes mellitus. Only one of these patients continued to require daily insulin; the others were managed on diet alone.[29]

Pituitary tumors are treated by surgery or by some form of irradition followed by replacement therapy when indicated. In an attempt to evaluate these forms of treatment, we have tabulated the results in those treated with surgery alone, those with surgery and x-

ray therapy, those with x-ray therapy only and, in addition, those patients whom we have treated symptomatically, either because of refusal of specific treatment or lack of evidence of continuing growth of the tumor. This latter group has given us some insight into the natural course of these tumors. In addition to the usual methods of treatment, one of our patients, because of a peculiar problem of extension into the sphenoid sinus with spinal fluid fistula, was treated with yttrium^{90} implantation.*

Adequate follow-up evaluation has been accomplished in over 90 per cent of the patients in this series. Subjective follow-up consisted of the patient's own evaluation of his condition, particularly in regard to his vision, persistence of headaches and his ability to perform work. A summary of this evaluation is shown in Table II. The visual improvement was not significantly affected by the type of treatment utilized, but probably reflected more the type of patient selected for each form of treatment. In other words, the patients chosen for x-ray therapy alone had better vision before treatment than those treated by surgery or a combination of surgery and x-ray. As might be expected, those patients who were treated symptomatically showed a higher percentage of poor vision, as some of them had progressive visual field loss. Surprisingly, however, 10 of this group showed an improvement in the visual fields by objective measurement. In three of these 10, this improvement was pronounced, indicating perhaps that some regression in the size of these tumors can occur spontaneously. The persistent headaches were higher in the surgically treated group but, here again, the tumor involved was usually larger and more likely to produce headache than in the x-ray treated patient. Likewise, the percentage of persistent headaches in the symptomatically treated patients was somewhat higher. There was no significant difference in the ability to continue working in the patients treated in various ways; but in the nontreated or symptomatically treated group there was a significant difference in the ability to perform work. In the acromegalic group the persistent headaches were not significantly different from the symptomatically treated and the x-ray treated patients; neither was the ability to perform work in these two groups significantly different.

TABLE II. FOLLOW-UP OF 100 PITUITARY TUMORS

		75 Chromophobe Adenomata				25 Acromegalics		
		Surgery 20 (12)	Surgery & X-Ray (18)	X-Ray 10 (8)	Symptomatic Trt. 25 (14)	Surgery (1)	X-Ray Rx (8)	Symptomatic (8)
Vision	Good	42%	61%	63%	64%	+	62.5%	75.0%
	Diminished	58%	33%	37%	8%		25.0%	—
	Poor	—	6%	—	28%		12.5%	25.0%
Persistent headaches		17%	6%	—	28%	0	12.0%	12.5%
Ability to work	Full	83%	78%	75%	43%	+	62.5%	62.5%
	Partial	17%	16%	25%	14%		12.5%	—
	None		6%		43%		25.0%	37.5%



Fig. 5. Fractional pneumoencephalography demonstrating extrasellar extension of a pituitary tumor. On the right is a laminagram of the sellar region taken at the time of pneumogram, delineating effectively limits of the tumor.

*Chicago Tumor Institute for Radiotherapy.

Percentage visual acuity and peripheral field change were calculated following treatment with x-ray, surgery, and x-ray plus surgery.[30] The efficiency of each eye was tabulated separately. A composite efficiency was also determined so that objective differences be-

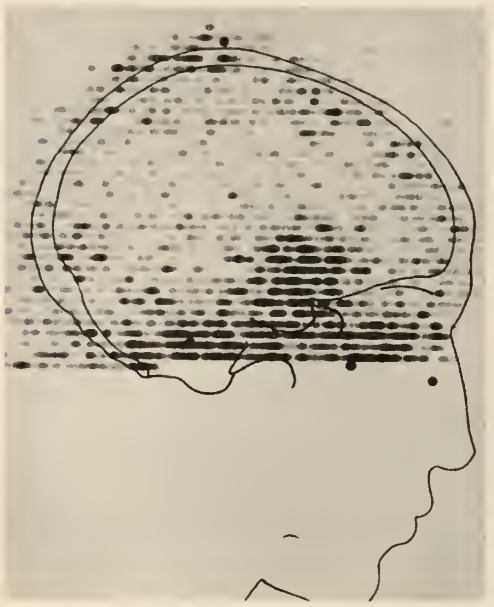


Fig. 6. Mercury^{203} brain scan in proven case of chromophobe adenoma.

tween groups might be observed. These findings are presented in Figure 9 as percentage improvement in visual acuity and peripheral fields after treatment. There is apparently more visual acuity improvement in the left than in the right eye. Chamlin (1955) observed that the right eye exhibited a more profound loss in visual acuity than the left.[31] His observations were made on patients with pituitary tumors before treatment. All of our patients with surgery had right frontal craniotomies. It is conceivable that the right optic nerve underwent more trauma than the left; however, the same discrepancy is noted in the group of patients having received only irradiation, and no valid conclusion can be drawn from these observations. There was considerable variation in percentage improvement among patients in each group, but there was no gross difference in the improvement of visual efficiency between the groups treated by x-ray, surgery, or a combination of these. The survival period is of interest in these patients. Seventy-one per cent of the chromophobe adenomata and 84 per cent of the acromegalics are still alive, and 29 per cent of the chromophobe group and 16 per cent of the acromegalics are dead, with the time of death occurring from two months to 20 years post-treatment. This includes one postoperative death which occurred two months following surgery and in whom no significant cause of death could be found at autopsy, although a small well encapsulated abscess was found in the cerebral hemisphere opposite the side of surgical exploration. One of the untreated patients died of pituitary apoplexy. The remaining deaths attributed to the pituitary tumor occurred primarily in the patients who had received no form of therapy or inadequate replacement before steroid therapy was generally available.

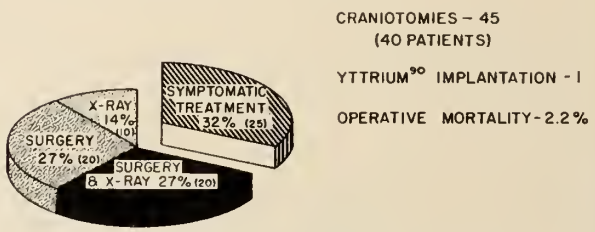


Fig. 7. Outline of treatment performed on 75 cases of chromophobe adenomata. Note that 25 cases had no formal treatment. A considerable number of these cases showed spontaneous regression of symptoms.

The causes of death in these cases (22) were the following: cardiac disease (2), kidney disease (4), hypernephroma (1), cerebrovascular accidents (2), and cause of death could not be ascertained (5). In the acromegalic group, one died from carcinoma of the stomach, another of a cerebrovascular accident, and in two the cause is unknown.

Discussion and Summary

The management of the patient with a pituitary tumor has remained controversial through the years, with emphasis early being placed on a surgical approach, either trans-sphenoidal or transfrontal, particularly under the influence of Cushing and his disciples. The later trend was toward x-ray therapy, as x-ray techniques improved and newer methods for delivering high dosage irradiation became available. It is interesting that Doctor Horrax, a neurosurgeon and an associate of Cushing's for many years, became one of the strongest advocates of irradiation therapy.

The issue is not settled, however, and it is likely that both methods are necessary and will continue to be used as specific indications for each type of therapy become more clarified. A good example of this is the patient in our series who was treated with yttrium^{90}. Actually, this patient had an unusual problem with erosion of the tumor through the posterior wall of the

sphenoid sinus, with formation of a spinal fluid fistula. An attempt to remove this tumor was made transsphenoidally on two occasions without success. He was treated with x-ray therapy unsuccessfully, and finally the tumor was implanted with yttrium^{90} pellets. This destroyed the tumor, but a low-grade infection or inflammatory reaction ensued, and surgery by the frontal approach became necessary approximately one month following treatment because the patient suddenly lost most of his vision as a result of dense adhesions around the optic chiasm.



Fig. 8. Yttrium^{90} pellets implanted in pituitary tumor.

A newer concept (Ray, 1962) in the management of early eosinophile tumors by total hypophysectomy has also been made possible with the availability of adequate endocrine replacement.[29] In some patients this led to reversal of the connective tissue changes in the hands, feet and face, reversal of cardiomegaly and hypertension, and improvement in the diabetic status. As pointed out earlier, these improvements have not previously been prominent with tumors treated either by conventional x-ray therapy or by partial surgical removal.

While it is still in the experimental stage, it is possible that proton beam irradiation may replace former methods of therapy, as this permits accurate placement of lesions of specific size in an area confined to the tumor, without significant injury to the adjacent structures or to the scalp. This would in effect amount to a nonsurgical hypophysectomy.[32]

The criteria for the selection of cases for treatment has been fairly well established at this institution. It is our opinion that the indications for surgery are: sudden loss of vision from pituitary apoplexy, rapidly progressing loss of vision (particularly with loss of visual acuity, as well as visual field defects), marked loss of visual acuity when first seen, large supra- or parasellar extension of the tumor, failure of x-ray therapy to halt progressive visual field changes, early active acromegaly, particularly in those patients in whom some improvement in features can be expected, and finally in those few cases of Cushing's disease



Fig. 9. Improvement in visual acuity and peripheral fields observed in cases of chromophobe adenomata following treatment. Figures represent percentage improvement over pretreatment status. Note disparity between left and right eyes.

when the tumor is suspected to be in the pituitary rather than in the adrenal gland.

X-ray therapy is recommended for those cases in whom a mild to moderate progressive improvement of the visual acuity and fields has been observed. Secondly, it is used as a supplement to surgery for large tumors which have been subtotally removed. Lastly, it should be recommended when there is evidence of rapid regrowth of the tumor following short-term remission after surgery.

About one-third of our patients were treated symptomatically without either surgery or x-ray therapy, treating only the endocrine dysfunction and other symptoms such as headache. Undoubtedly, some of these patients should have been treated and in some treatment was recommended and refused. Others, however, have actually remained static for long periods of time. Three of these patients have had very definite improvement in their visual fields, suggesting a spontaneous regression in the size of the tumor. In general, the patients whom we have purposely not treated have been those who have shown no significant endocrine dysfunction and no significant change in the visual fields over a prolonged period of observation.

At present, it is still obvious that the treatment of the patient with a pituitary tumor must be individualized, and our method of reaching a decision is by close

cooperation between the internist, endocrinologist, ophthalmologist, radiotherapist and neurosurgeon. Decision is made after careful evaluation of the total problem, and no "set" form of treatment can be recommended for all patients.

Summary

1. A series of 100 pituitary tumors has been reviewed.

2. An outline of laboratory and diagnostic procedures used in establishing the diagnosis of pituitary tumor is presented.

3. Clinical manifestations of the patients with chromophobe tumors have been compared with the cases presenting signs and symptoms of acromegaly.

4. Objective visual function has been tabulated in each case and a comparison is made between the cases undergoing surgery, irradiation or a combination of these forms of treatment.

5. Adequate follow-up has been accomplished in 90 per cent of the cases presented.

6. No gross difference in the improvement of visual efficiency between the groups treated by irradiation, surgery or a combination of these is observed.

7. Management of pituitary tumors is summarized and indications for surgery and irradiation are outlined.

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Amnionitis—Evaluation of a Diagnostic Procedure

A. G. Seski, M.D.
L. A. Miller, M.D.
S. Guindi, M.D.

Detroit, Michigan

THE OBSTETRICIAN is continually striving to reduce fetal wastage and neonatal morbidity and mortality. The neonatal mortality rate in the United States at present is approximately 19 to 20 per 1000 live births. Many believe with Clifford[4] that there should be a saving of 20,000 or more babies per year in the United States by applying existing knowledge and techniques. Although the most important single cause of death in the newborn is asphyxia, infection plays a predominant role in fetal loss and neonatal mortality and morbidity.

In a study made by Arey and Dent (1945-1947) infection was considered the primary cause of 13 per cent of the neonatal deaths and a contributory cause in approximately 27 per cent.[9] MacGregor, in a survey of 618 neonatal deaths reported in 1946, found that 190 (30.7 per cent) were attributable to an infectious process.[3] Similar studies have shown repeatedly high incidences of infection as a primary and contributory cause of death.

Bacterial contamination of the amniotic cavity has been recognized as the main potential source of fetal infection. Evidence of this is the finding of established pneumonia in stillborn infants, and bronchopneumonia in newborn infants who have died during their first day of life. The history associated with these infants often reveals prolonged rupture of fetal membranes or prolonged labor.[1]

It would appear that with the advent of antibiotics and control of infectious processes in our modern day practice of obstetrics and pediatrics, infection as a main cause of neonatal death would be easy to eliminate. However, the early diagnosis of amnionitis is often difficult and for this reason the mother and infant are frequently untreated.

The literature contains many laboratory techniques to aid the clinician in diagnosing infection during the neonatal period, for there is no question of the importance and advantage of early diagnosis of amniotic infection. The techniques that have been used are based on the finding of invasion of leukocytes into the secundines. Rapid permanent sections, chorionic imprints, frozen sections of placenta and cord, smears of the gastric content at birth have all been advocated.

A test which we have found and long believed to be simple and rapid in evaluating the presence of infection in association with amnionitis has been the "whole mount" technique. We have therefore attempted to prove the value of this test as a routine procedure, adopting it in this hospital on all cases of ruptured membranes, prolonged labor, premature deliveries, stillbirths and complicated deliveries. The amnion in all these cases was examined as a "whole mount" and confirmed by either permanent or frozen section. The advantage of the "whole mount" is that it can be performed at any time of the day or night by the obstetrician, eliminating the need for laboratory personnel, thus serving as a guide to early definite therapy of the exposed infant.

Method and Result

The "whole mount" procedure is simply that of taking a minute section of placental membrane measuring approximately 2 mm x 3 mm, placing it on a glass slide and staining it with methylene blue for approximately two to three minutes. A cover slip is then pressed well down over the tissue and the specimen examined histologically for leukocytes present in the tissue.

Fifty patients who had clear appearing amniotic fluid at time of rupture of the membranes were utilized as

Author
A. G. SESKI, M.D.



From the Department of Obstetrics and Gynecology, Woman's Hospital, Wayne State University College of Medicine, Detroit, Michigan.

a control group to initiate our study. A culture and sensitivity was taken of this fluid, as well as sections of the placenta, membrane, cord and a "whole mount" preparation for histological study.

Specimens of amniotic fluid and vaginal discharge were taken routinely from the mother with prolonged

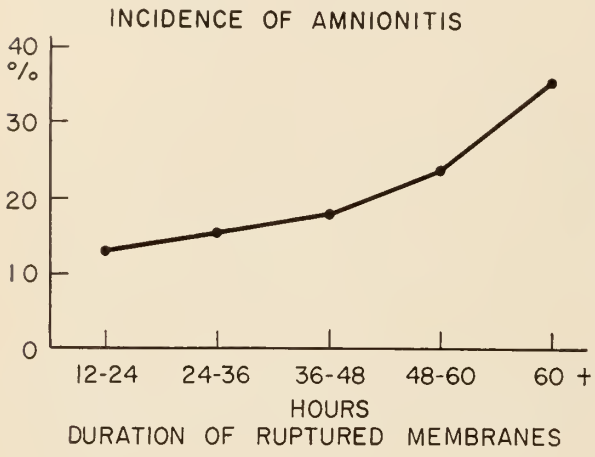


Fig. 1.

rupture of membranes for culture and sensitivity. Sections of these placentas, membranes and cords were also studied histologically and by the "whole mount" procedure. Upon delivery of the fetus, a smear from the axilla and another from the groin were taken for culture and sensitivity. An additional study of the placenta and its membranes was made on all patients who had intact membranes but yet who had malodorous, stained placentas and amniotic fluid at the time of delivery which might suggest the presence of infection.

The results of our study were gratifying. In the control group of 50 patients, all cultures, histological studies and "whole mounts" made from and of the amniotic fluid, placentas and vernix revealed an absence of bacterial infection.

There were 548 patients of 4,636 deliveries (8.4 per cent) who had ruptured membranes prior to onset of labor. Ninety-two of them had histologic or cultural

TABLE I.

Type of Cases	Total No.	Amnionitis (Histological)	Positive "Whole Mounts"	Positive Cultures
Controls	50	0	0	0
Ruptured Membranes	548	92	92	78
Intact Membranes with suspected amnionitis at delivery	50	9	9	5

evidence of infection, though not all of them had clinical evidence of amnionitis. As expected and demonstrated in Figure 1, the incidence of amnionitis increased with the duration of ruptured membranes. Fortunately, more than 70 per cent of those patients who do develop ruptured membranes will initiate spontaneous labor within 48 hours and will deliver a living offspring.[6] It was surprising to note that a significant number of patients exhibited evidence of amnionitis in spite of intact membranes (Table I).

The organisms cultured from the amniotic fluid and vernix of the child were largely E. coli, coagulase negative staphylococci and streptococci faecalis which

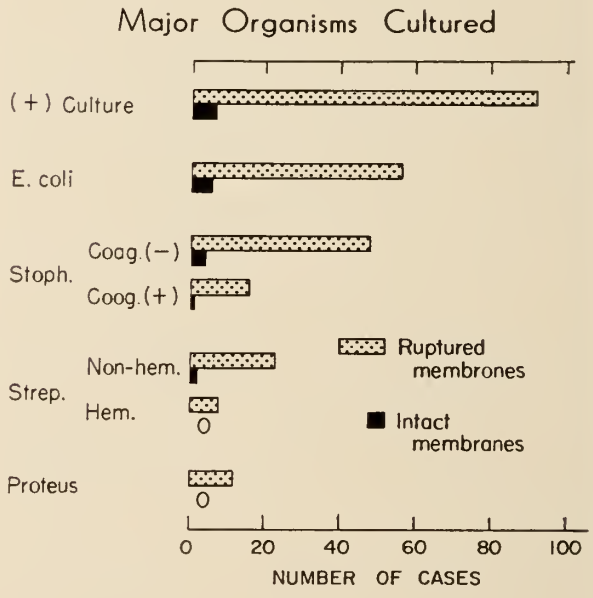


Fig. 2.

are common to the vagina (Fig. 2). Senstitivity tests of these organisms demonstrated the greatest response to penicillin, streptomycin and chloramphenicol (Fig. 3).

Though the diagnosis of amnionitis can be confirmed by histological and cultural evidence without difficulty, a great deal of time is utilized awaiting results. It has become apparent that the patient and particularly the fetus should be treated immediately if the maximum protection is to be gained for both involved. Utilizing the "whole mount" preparation, diagnosis can be confirmed very simply and quite quickly and gave excellent diagnostic results in all our patients.

Etiology

To understand the principle on which diagnostic tests such as the "whole mount" are based, one must fully understand the etiology of infection. The occur-

rence of intrauterine infection under certain conditions during labor has long been known, but the etiology of placental infection is still controversial. Most of the early workers such as Kobak (1930)[8] and Siddall (1928)[10] believe that this inflammation comes from a bacterial infection. Though chemical inflammation of the amnion has been produced experimentally in animals, it appears that the inflammatory changes which appear in humans results from bacterial contamination of the amniotic fluid.

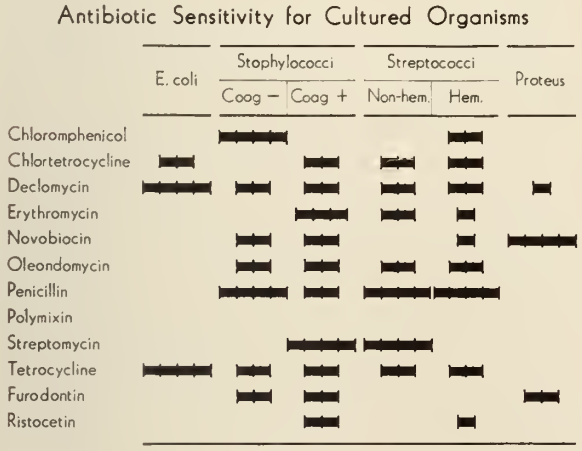


Fig. 3.

Theoretically, the amniotic fluid may become contaminated by bacteria in three different ways: (1) by ascending infection through intact or ruptured membranes, (2) by hematogenous spread to the placenta and membranes with secondary invasion of the fluid, and (3) through the Fallopian tube. Infection of the fetus can therefore occur through the blood, placenta, fetal circulation, or via contamination of the superficial chorion vessels and fetal circulation or, as most commonly believed, by fetal aspiration. The main factors conducive to contamination are the actual duration of rupture and the presence of active labor. It has been suggested that the penetration of germs is aided possibly by the creation of a "suction" effect by the uterus. Also, the number of rectal and vaginal examinations during labor contribute to the amount of contamination. However, the severity of the infection and inflammation would appear to depend upon the virulence of the organism, the size of the inoculum, and the duration of the infection.

Pathology

Because of the variability of the gross appearance of the infected secundines, histological examination is a necessity to diagnose amnionitis. The leukopedesis in

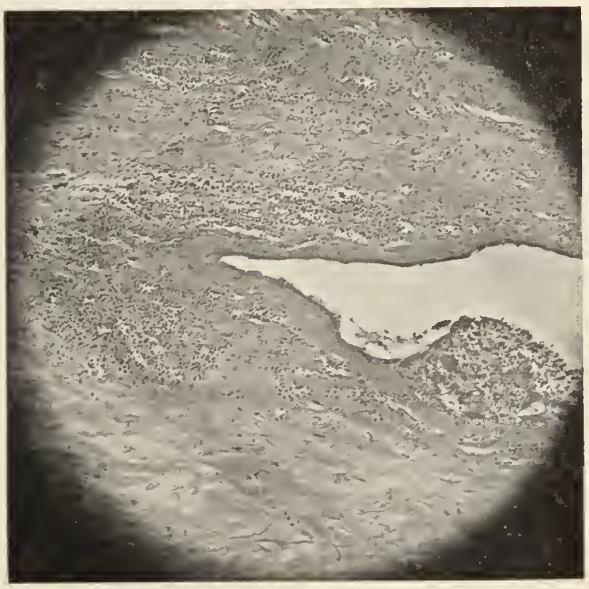


Fig. 4.

secundines produced by bacterial infection is the usual finding in these cases and can be determined by a number of reliable methods. The simplest technique is "whole mount" which we have confirmed by frozen and permanent sections.

Microscopic examination reveals varying degrees of inflammatory infiltrates of mononuclear and polymorphonuclear leukocytes infiltrating the connective tissue. It is this infiltration which we recognize under "whole mount" preparations (Fig. 4).

Comment

Bacteria are normally present in the vagina or are introduced manually by examination or instrumentation. As a rule these organisms prove to be harmless during the normal course of labor with a relatively short second stage period, and with the head favorably engaged in the pelvis.[5] However, should the membranes rupture prematurely with the head high and floating the existing organisms or those introduced manually readily find their way into the amniotic cavity. The infection route is through the vagina, liquor amnii and then either via the transplacental route or via the respiratory tract of the fetus by aspiration.

The prognosis for the fetus becomes more unfavorable as the period between the rupture of the membranes and birth of the fetus becomes unduly prolonged. If a sufficient period of time is allowed for invading bacteria to flourish, the elaborated toxin is capable of attracting leukocytes wherever the toxic

effects may penetrate. This leads to placental reaction, inflammation and associated purulent amniotic fluid.

The membranes, however, are not an essential barrier to microbic invasion from the vagina. Harris considers the uterus invariably to be infected after six hours of labor, regardless of the status of the fetal membranes.[8]

We have found nine cases in which membranes were ruptured only at delivery and yet the amniotic fluid had a foul smell and the associated placenta and membranes resembled those seen in amnionitis. Cultures and sections on these specimens revealed proof of the presence of amnionitis. While it is possible that the membranes may become infected from an intra-abdominal lesion via the Fallopian tubes or from an infection of the uterine wall or cervix, it is doubtful that these routes are responsible for an infection. It would appear more likely that the membranes over the cervix lose their effectiveness as a barrier to bacteria.

Since it is assumed that the presence of fever indicates intrapartum uterine infection, an impressive elevation of temperature immediately jolts the physician into treatment of the patient. Siddall[10] found 17 in 1000 deliveries with temperature elevations during labor to be at least 100° F. which could not be explained by any intercurrent condition. In 15 of these 17 cases, the amnion and chorion of the placenta were acutely inflamed. It would thus seem justifiable to assume that unexplained fever during labor is good evidence of intrapartum infection. However, 33 of 48 cases having severe infection evident histologically in the placenta in his study were without fever during labor. Therefore, it by no means holds that a normal temperature is a reliable index of the absence of intrauterine invasion by bacteria. It is in these cases particularly that the "whole mount" preparation can be utilized, positively diagnosing amnionitis, thus directing the physician's attention to early treatment in previously unrecognized cases.

Fetal loss accompanying intrapartum fever above 100° F. ranges from 10 to 50 per cent.[5] Certainly appropriate antibiotic therapy should be given to the mother if the oral temperature rises to 100° F. or above. The drug of choice should be determined according to sensitivity tests made on cultures from the cervix. In the event of delay in sensitivity results, we have chosen a broad spectrum antibiotic (until the most desirable one is reported). The routine use of antibiotic therapy as a prophylactic measure to a patient with ruptured membranes is not advocated.

The majority of babies are lost because of (1) prolapse of the cord, (2) intra-amniotic infection, and (3) prematurity.[7] The second indication, that of intra-amniotic infection, is our chief concern at present. For every degree in rise of maternal temperature above 100° F. there is a concomitant rise in the fetal requirements for oxygen of about 10 per cent. Some babies may, therefore, succumb from chronic anoxia under this circumstance.[8] However, the aspiration of fluid containing bacteria into fetal lungs is the major concern of amnionitis and, in many instances, has caused pneumonia and other severe infections with resultant deaths in the neonatal period. The obstetrician, in making an early and accurate diagnosis of amnionitis, can therefore prevent these deaths with early institution of therapy.

Conclusion

The "whole mount" technique is a practical clinical method of diagnosing amniotic infection. It is our opinion that in all cases of prolonged labor, ruptured membranes, premature delivery and complicated deliveries, the method should be used immediately after delivery and, if positive, all such infants should be started on antibiotic therapy. If the baby has a tentative diagnosis of infection, the confirmation of amniotic infection by the "whole mount" warrants vigorous antibiotic therapy. On the other hand, if the "whole mount" is negative, this should preclude the use of antibiotics.

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The Value of Digital Plethysmography in Detection Of Arterial Disease in the Lower Extremities

Ahmed H. Mahmoud, M.B., B.Ch., D.P.H., M.P.H.
Andrew J. Zweifler, M.D.
James Conway, M.D., Ph.D.
Ann Arbor, Michigan

RECENT advances in electronics have allowed development of simplified techniques for the measurement of volume changes in limbs and digits. A profusion of plethysmographic devices designed for "office use" are presently available to the practicing physician, and the work of others[1-8] has left little doubt that such instruments are able to detect the effects of arterial insufficiency. A related problem is the value of methods using these tools in the detection of arterial disease in its early stages. In order to determine this, it seemed important to obtain the range and variability of currently used tests in a large number of normal individuals and to compare these with a small group of abnormals. Two of the most widely used tests were chosen for study:

1. The hallucal pulse wave for determination of the crest time and dicrotic notch.
2. The difference in systolic blood pressure between the arm and the ankle.

Material and Methods

Subjects.—"Normals" were selected from individuals examined during a community health survey in Tecumseh, Michigan.[9]* All subjects in this category were 20 years of age and over, devoid of symptoms of arterial insufficiency, and all had palpable peripheral pulses. The patients studied were divided into two groups. The first group, the "abnormals," were patients with classical intermittent claudication and impairment or absence of appropriate pulses. The second group, the "questionables," were patients with hypertension and/or hypercholesterolemia, in whom one or both pedal pulses were absent, but who had no symptoms of vascular insufficiency. Subjects in the latter two categories were selected from patients attending the Hypertension-Vascular Unit of the University of Michigan Hospital.

Methods.—Subjects were examined in the recumbent position at a room temperature of 75 ± 5° F. For the data on normal subjects, all the procedures were performed using the same apparatus and the measurements were made by one person (AHM). Similar apparatus was used for the clinical studies but a different observer made the measurements.

1. *Digital Plethysmography*

Technique.—The digital pulse was detected by impedance plethysmography.[1] Three pieces of aluminum foil, each folded four to five layers thick, about a quarter inch in width and four inches in length, were used as electrodes. One electrode was wrapped around the base of the great toe; the second placed in a similar manner just proximal to the nail of the same toe. The third, a grounded electrode, usually was wrapped around the fifth toe of the same foot. Points of application and the foil itself were rubbed with EKG electrode paste before the electrodes were positioned on the skin. The hallux electrodes were connected to the two electrode outputs of a model 3H impedance plethysmograph,* and the third piece of foil was connected to the ground electrode of this machine. Pulse wave tracings were recorded with a Burdick electrocardiograph for the normal subjects and a Gilson polygraph for the patients.

*Parks Electronics Lab.

From the Department of Internal Medicine, Medical School, and the Department of Epidemiology, School of Public Health, University of Michigan, Ann Arbor, Michigan.
Doctor Zweifler formerly was post-doctoral fellow of the National Heart Institute.
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Doctor Conway is an Established Investigator of the American Heart Association.
Studies on patients were supported by a grant from the Aares Institute.
*In collaboration with the Research Staff, Cardiovascular Research Center, University of Michigan, and the Tecumseh Community Health Study.

Measurement of Crest Time.—The crest time of the pulse wave was measured in hundredths of a second from the start of the wave to its peak. Each value recorded was the mean of five pulses.

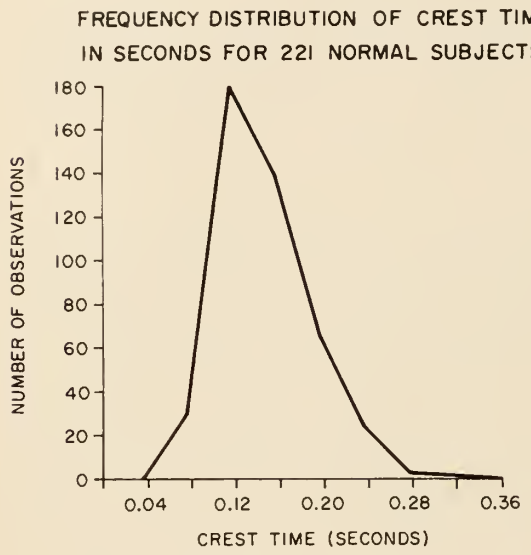


Fig. 1. Frequency distribution of crest time in each leg of 221 normal subjects.

Dicrotic Notch.—Presence or absence of a notch on the catacrotic limb of the pulse wave was recorded.

Subjects.—Data were obtained from 221 normal subjects and 58 patients.

2. *Brachial and Ankle Systolic Blood Pressure*

Technique.—A blood pressure cuff 5″ in width was applied about the ankle. Pressures were registered on an anaeroid manometer attached directly to the inflation bag of the cuff. Pulse waves were recorded from the great toe by impedance plethysmography as described above. Systolic pressure at the ankle was determined as that cuff pressure which just occluded the digital pulse. Brachial pressures were determined by the auscultatory method utilizing a standard sphygmomanometer. The ratio of the systolic pressure in the arm to that measured over the ankle has been used to express the difference between these two areas.

Subjects.—Data were obtained from 221 normal individuals and 31 patients.

Results

Hallucal Pulse Wave Analysis

Crest Time.—The distribution of values in the large group of normals is illustrated in Figure 1. The range was from 0.06 to 0.30 seconds, with the peak at 0.12 seconds. Figure 2 combines the cumulative frequency distribution of the data from these same normal subjects with that of the abnormal and questionable patients. Amongst the normals, 81 per cent of the crest times were shorter than 0.16 seconds. Forty-two per cent of the clearly abnormal subjects and 67 per cent of the questionable patients were found to have crest times in this same range. Although there is an obvious tendency for abnormals and questionables to have longer crest times, the overlap among all groups is great.

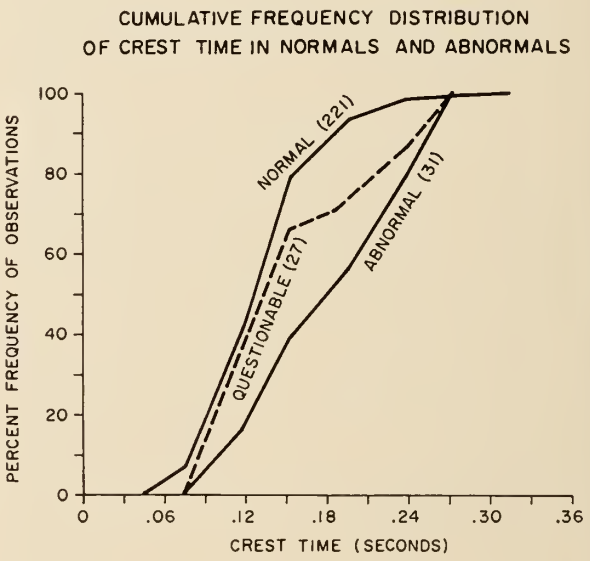


Fig. 2. Cumulative frequency distribution of crest time in normals and abnormals.

Dicrotic Notch.—In the normal group, a dicrotic notch was present in 60 per cent, absent in 24 per cent and questionable in 16 per cent of the subjects. The notch was absent in 53 per cent (16/30) of the vascular patients studied, but it was present in the remaining 47 per cent (14/30).

Arm/Ankle Ratio of Systolic Pressure.—Figure 3 is a frequency distribution curve of arm/ankle systolic blood pressure ratios in the same 221 normal individuals. Values range from 0.7 to 1.3 with a peak between 0.9 and 1.0. Cumulative frequency distribution curves for all three groups are combined together in Figure 4. Among the normals, a ratio of less than 1.1 was found in 91 per cent of the subjects. The findings in questionable patients were quite similar; 61 per cent had ratios less than 1.1. Abnormals, however, were definitely separated from the other two groups. All of these 18 patients with claudication had ratios greater than 1.1 and in 15 of them the value exceeded 1.3.

Discussion

Apparently, crest time of the digital pulse varies widely among normal individuals. This range overlaps considerably that obtained in patients with obvious peripheral arterial disease. The test then can have no value in the detection of subclinical vascular difficulty. The arm/ankle systolic pressure ratio on the other hand does appear to be a good objective method for documenting the presence of significant arterial occlusion. Unfortunately, however, it too fails to separate asymptomatic patients with absent pulses from normal

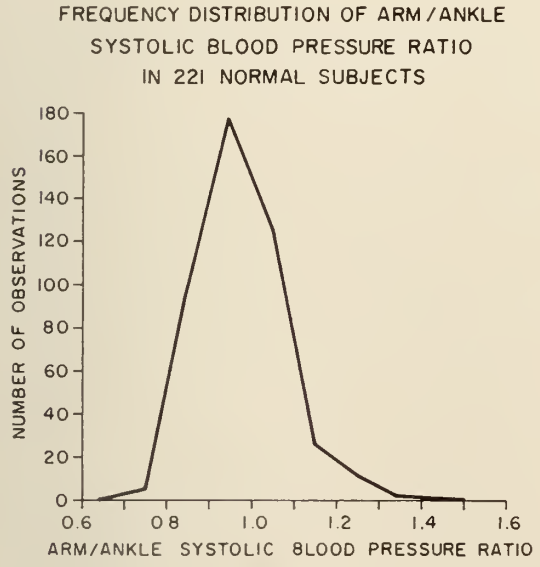


Fig. 3. Frequency distribution of arm/ankle ratio for systolic blood pressure in each leg of 221 normal subjects.

individuals. As a screening device for determining the presence or absence of occlusive disease of peripheral arteries in the early stages, it appears then to have little value. It is useful, however, as a confirmatory test in patients with clinical disease and in patients complaining of calf pain suggestive of intermittent claudication with a normal physical examination. In such incidences a normal arm/ankle ratio lends laboratory support to the clinical impression that significant arterial disease is absent.

Others have reported that the first change in pulse form produced by arterial obstruction is loss of the dicrotic wave.[3] In our 221 normal subjects the dicrotic notch was absent in 24 per cent, questionable in 16 per cent and clearly present in only 60 per cent of the cases. Unless we are to accept the idea that 40 per cent of these people are in fact abnormal, it appears that this test is not an accurate indicator of the existence of arterial disease. We have also measured calf blood flow during reactive hyperemia in a number of our abnormal patients utilizing the Whitney resistance strain gauge,[10] but have not found this method to be superior to the arm/ankle ratio in the detection of

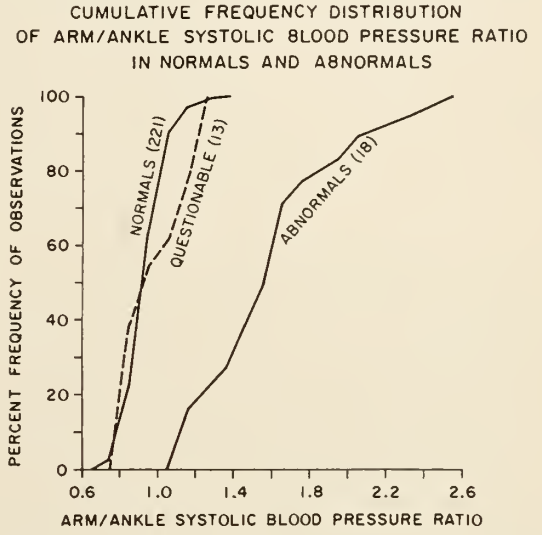


Fig. 4. Cumulative frequency distribution of arm/ankle systolic blood pressure ratio in normals and abnormals.

occlusions. It is obvious, therefore, that methods keener than these are needed to detect the manifestations of subclinical arterial disease. Our findings indicate that qualitative analysis of the pulse wave will not solve this problem. The solution will come only with the development of entirely new techniques capable of revealing small variations from a narrow normal range.

Summary

1. Crest time of the hallux pulse wave was measured with the impedance plethysmograph in 221 normal, 31 abnormal, and 27 "questionable" individuals, and arm/ankle systolic blood pressure ratios were obtained in the same group of normal subjects, 13 "questionables" and 18 abnormals. Presence or absence of a dicrotic notch on the hallucal pulse wave was noted in 221 normal subjects and 30 patients with obvious or suspected arterial disease.

2. Overlap was very marked in crest times from normal, "questionable" and abnormal groups. The arm/ankle ratio did demonstrate advanced arterial disease quite well, but could not separate normal from "questionable" people. The dicrotic notch was often absent in normal individuals.

3. Adequate detection of subclinical arterial disease demands the development of new laboratory techniques.

(References are on Page 1203)

Diagnosis and Treatment of the Hyaline Membrane Syndrome and Management of the Newborn Baby of the Diabetic Mother

William D. Cleland, Jr., M.D.
Port Huron, Michigan

Hyaline Membrane Syndrome

ONE of the major problems encountered in the newborn period is the occurrence of respiratory distress resulting from the deposition of hyaline membranes in the infant lungs. Although this syndrome has been recognized in babies born of apparently uncomplicated pregnancies at full term, it is much more frequently seen in babies born prematurely, or to diabetic mothers. The incidence is also somewhat higher in those born by cesarian section, particularly where maternal bleeding from placenta praevia and other causes has occurred. There is also a feeling that intrauterine distress regardless of cause is in itself a predisposing factor. The hyaline membrane phenomenon is perhaps the most common single cause of neonatal death, since these membranes and the atelectasis that accompanies them are the most commonly found abnormality in early neonatal death.

Although the target of extensive investigation over many years, the pathogenesis of the condition remains a matter of considerable debate. Furthermore, since repeated studies have usually failed to agree on the efficacy of a variety of suggested therapeutic measures, no single regime can be proposed as applicable in every patient. It is beyond the scope of this presentation to review the extensive historical material, the multitude of theories as to pathogenesis, the details of described pathological changes, the relatively recently defined abnormalities of physiology, or the many investigations regarding therapy. The reader who is so interested is directed to, among others, the recent monographs by Cook, Barrie and Avery[1] and by Gregg and Bernstein.[2]

From the extensive investigation of the last decade, there has evolved a clarification of the clinical and radiological features of the disease, so that early recognition is quite possible and differential diagnosis is usually not too difficult. Although some of these babies appear to be normal at birth and for some hours thereafter, the great majority reveal abnormalities at birth; namely, delayed onset of respirations, initial tachypnea or bradypnea and low Apgar score.[3] Within a few minutes to a few hours after birth, respiratory distress appears in the form of dyspnea, tachypnea and inspiratory retractions. Severity and prognosis at this time may be usefully assessed by the arbitrary scale proposed by Silverman and Anderson.[4] The retractions may be extremely severe with maximal depressions of the sternum with each inspiration. An expiratory grunt usually occurs early, and fine crackling rales are often heard throughout all or portions of the lung fields. Cyanosis is relieved by oxygen unless the situation has become terminal. As the respiratory distress progresses, the baby becomes tired, and this, accompanied by anoxic changes occurring in the central nervous system will lead to flaccidity and unresponsiveness. Coughing is infrequent. Edema may become fairly marked, a systolic heart murmur may be heard, and terminally the liver may enlarge and the body temperature will tend to be low. If obtainable, laboratory studies will reveal a lowered blood pH due to both metabolic and respiratory acidosis; frequently, elevated serum potassium levels are obtained. The chest x-ray characteristically reveals a diffuse reticulogranular-appearing pattern in the early stages, while in the late stages the lung fields appear almost airless. Occasionally tension pneumothorax may complicate the underlying condition. Death occurs within the first 48 to 72 hours; if not, complete recovery usually occurs.

Suggestions regarding prevention of the hyaline membrane syndrome must be offered timidly, for, as pointed out by Gregg and Bernstein,[2] of the several proposed, no measures have valid proof of general applicability. Aspiration of the stomach is carried out routinely in some institutions. Certainly it would seem wise as an adjunct to adequate gentle suctioning of the airway, when indicated, to also aspirate the stom-

ach when material in the nasopharynx is found to be copious or when the baby is regurgitating stomach contents after removal to the nursery. The high incidence of the syndrome in prematurely born babies contraindicates elective cesarian section before the 36th week of gestation. The recent studies of Cohen and co-authors[5] would cause one to give thoughtful consideration to the conservative management of placenta praevia whenever possible, rather than performing perfunctory cesarian section. Enough evidence has been presented by Apgar and co-authors[6] to implicate asphyxia from any cause as a predisposing factor to encourage the use of local anaesthesia rather than general cyclopropane anaesthesia in those instances where maternal diabetes, prematurity, et cetera are involved.

Since the treatment of the hyaline membrane syndrome is mainly supportive, first consideration should be given to the important principles of care of the apparently well premature or full term infant[7] with additional special measures provided as the clinical course of the disease progresses or regresses. A temperature controlled, isolated environment is paramount. The nursery provided with an incubator of the caliber of the Isolette will be in a good position to offer the baby an optimum chance for recovery. These sick babies should be subjected to a minimum of handling beyond that necessary for clearing the upper airway, gentle manual stimulation and carrying out any specifically prescribed procedures. There is a tendency for hypothermia to develop, and the incubator temperature should be adjusted appropriately. Isolation from possible sources of infection cannot be overly emphasized because of the threat of superimposed pneumonia. Although suggested by some as a routine measure, the iatrogenic hazard of various antibiotic and chemotherapeutic agents when used on premature and even full term newborn infants have been recently reported by various authors. For assistance in the selection of dosage the reader is directed to the recent report of the committee on infectious diseases of the American Academy of Pediatrics.[8] Coverage against both Gram-positive and Gram-negative invaders should be considered in the selection of any drugs used prophylactically. The occurrence of signs of pneumonia in the clinical course or chest x-ray are indications for sputum culture and drug sensitivity tests, broad spectrum coverage being maintained until laboratory results are obtained. Oxygen is obviously recommended, and in concentration sufficient to relieve cyanosis of other signs of hypoxia such as restlessness or lethargy. The hazard of prolonged oxygen use will be lessened by care in readjusting the concentration in the incubator to relieve hypoxic signs as the severity of respiratory obstruction changes. The use of mist is controversial; one cannot discount the fact that these babies usually seem to breathe easier when placed in an environment of high humidity. The point has been made that the benefit obtained is not through a direct effect on the hyaline membrane desposition, but an indirect one in enhancing temperature control by reducing water (and thereby heat) loss in the environment of 80-90 per cent humidity.[9] In the desperately ill baby with severe sternal retraction, the use of sternal fixation by a suture through the xiphoid process attached to a rubber band brought through the hole in the top of the Isolette and tied taughtly to a pencil or similar object placed over the opening, has been reported by Schaffer and his associates[10] as being strikingly beneficial in several cases where the steady downhill course caused dispair as to the possibility of survival. Any apparent benefit in improving pulmonary circulation through the use of rocking devices has been disproved by Avery and O'Doherty.[11] Intravenous fluid therapy using glucose and sodium bicarbonate[12] or glucose and hypotonic saline[13] has been found to be of benefit in lowering the elevated serum potassium level in the later stages of the disease. If intravenous fluid administration is not feasible, the insertion of a premature (No. 8 French) polyethylene feeding tube through a nostril into the stomach will often nicely facilitate fluid administration. Fixation of the tube by gauze strips and collodion rather than by adhesive tape is recommended.

Infant Born of a Diabetic Mother

As mentioned in the preceding paragraphs, the hyaline membrane syndrome is commonly found in infants born of diabetic mothers. Management of the resultant respiratory distress as outlined is equally applicable in these cases. However, concomitant complications are frequently encountered, and these bear special consideration. These infants are characteristically of greater than average size, and at 35 to 37 weeks gestation may be well over 2500 Gm. (5.5 lbs.); however, being physiologically less mature than suggested by their weight, they must be treated accordingly. Fluid retention is greater than in the usual newborn, and the resultant subcutaneous, pulmonary and cerebral edema is a threat to immediate survival. Tracheobronchial secretions are likely to be obstructive, and postural drainage along with careful suctioning of the pharynx with a soft catheter is indicated. If secretions are copious and likely to have been ingest-

ed, the stomach should be emptied. Fluids are withheld or markedly restricted initially in order to encourage dehydration.

As pointed out by Gellis and Hsia,[14] mortality in these infants can be lessened by intensive prenatal care and with consideration given to selection of obstetrical procedures and associated anaesthesia. The maternal diabetes should be carefully controlled throughout the pregnancy. Hopefully, this will lessen the risk of an anomalous baby and will minimize the extramedullary hematopoiesis, hepatosplenomegaly and cardiac enlargement frequently reported. Priscilla White has singled out the disturbance of maternal sex hormones as the most significant factor contributing to the disturbances in these babies and has produced a significant reduction in neonatal mortality in those cases showing abnormal balance of estrogen and progesterone by substitution therapy given the mother during pregnancy.[15] Whenever possible the mother should be admitted to the hospital for closer observation for a period prior to delivery. Gellis and Hsia[14] advise delivery of the baby at 35 to 36 weeks' gestation and allowing a trial of labor, if the cervix is favorable, before resorting to cesarian section. To lessen the hazard of neonatal hypoglycemia, withholding insulin on the day of delivery and the administration intravenously to the mother of 10 per cent glucose before and during delivery is advised.

Opinions vary considerably as to the frequency of significant hypoglycemia in these babies and as to its importance from the standpoint of survival of the infant. Consequently, some favor the routine administration of glucose and glucagon, others follow the blood sugar by serial determinations on the cord blood and then on the capillary blood in the first 24 to 48 hours after delivery (giving glucose orally or intravenously as needed to maintain the blood sugar above 40 mg. per cent) and still others advocate no treatment unless clinical signs of hypoglycemia occur. The latter has been the course followed by this author. One must realize, however, as pointed out by Odell and Cooke,[16] that hypoglycemia in the newborn may not manifest itself by seizures, or they may be so slight as to go unnoticed in the nursery. Indeed, the infant may simply be found in a shock-like state. The hypoglycemia of babies born of diabetic mothers usually occurs two to four hours after birth, and is more common with cesarian section. When discovered, the hypoglycemia can be reversed by the intravenous administration of 10 per cent glucose solution in a dose of 0.5 Gm/kg. body weight per hour, or the administration of large doses of glucagon.[16] Schaffer[10] and others administer the glucose in 0.45 per cent saline because of reports of a low blood pH.

Hypocalcemia in the first 48 hours after birth has been reported in babies born to diabetic mothers, and should be suspected if hyperirritability is present. A serum calcium level below 8 mg. per cent substantiates hypocalcemia as the cause, and the administration of calcium is indicated. If calcium gluconate is given intravenously, it should be given as an 8 to 10 per cent solution, and should be given slowly while listening to the heart to avoid serious bradycardia or cardiac arrest. Symptoms may not abate immediately and the amount required is variable. Oral calcium lactate or calcium gluconate may be sufficient. If calcium chloride is given orally, it should be mixed with milk; intravenous administration of calcium chloride is not advised.[16]

Summary

The diagnosis and treatment of those newborn babies encountering respiratory distress due to pulmonary hyaline membrane formation has been discussed. Careful observation and supportive management in a well-equipped nursery will tide the majority of these babies over the critical phase of the disease allowing them to reach the phase of spontaneous and usually complete recovery. The newborn baby of the diabetic mother will further benefit from careful prenatal and obstetrical management. If properly anticipated, postnatal complications can usually be successfully overcome.

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(Additional references on Page 1207)

Theophylline-Glyceryl Guaiacolate Capsules (Quibron®)

Clinical Results in Bronchial Asthma

Samuel J. Levin, M.D.
Robert A. Scherer, M.D.
Detroit, Michigan

AMINOPHYLLINE has been widely used as a reliable drug for the relief of bronchospasm in bronchial asthma since 1937.[1]

The active principle of aminophylline is theophylline-ethylenediamine (78 to 82 per cent). The relief obtained in asthma following the intravenous administration of theophylline (as aminophylline) is usually dramatic.

Many attempts have been made to formulate effective aminophylline preparations for oral use to decrease the need for intravenous administration. Most oral preparations are to some degree irritating to the gastric mucosa and may produce nausea and vomiting. Very few produce an effective blood level, which is necessary for relief of bronchospasm. It has been shown that the relief obtained is dependent on the height of the blood theophylline level and the rapidity with which an effective level is reached.[2,3,4] In contra-distinction to most oral preparations, it has been found that a hydro-alcoholic solution of theophylline facilitates absorption and quickly yields blood levels in most cases comparable to that effected by intravenous injection.[5,6]

One of us recently reported clinical and blood level studies in 38 children using a hydro-alcoholic formulation containing theophylline combined with glyceryl guaiacolate in elixir form (Quibron®).[5] Blood level theophylline studies were carried out in five patients. A good therapeutic blood level of theophylline was obtained in four of five patients. Sixty-nine per cent of children obtained a good to excellent clinical result.

Doctor Levin is Associate Clinical Professor of Pediatrics at Wayne State University Medical School; Director of Allergy at the Children's Hospital of Michigan; Associate Attending Pediatrician at Harper Hospital; and Associate, Division Internal Medicine (Allergy) at Sinai Hospital, Detroit.

Doctor Scherer is Instructor in Pediatrics at Wayne State University Medical School and Assistant Pediatrician (Allergy), the Children's Hospital of Michigan, Detroit.

Quibron® in capsule form was supplied originally as Product 5065-3A by the Mead Johnson Research Center, Evansville 21, Indiana.

The expectorant action of guaiacol has been well documented.[7] It has been found superior to potassium iodide in thinning mucus in bronchial asthma. For many years, guaiacol preparations have been used in the symptomatic treatment of asthma in preference to iodides since they are generally much more acceptable, especially to the young patient. No side reactions such as seen with iodides have occurred with guaiacol.

Quibron Elixir mentioned above, though effective, is inconvenient for adult patients who require doses in the 1 to 2 tablespoon range every 6 to 8 hours. For this reason, the manufacturers made available to us some months ago a similar formulation in a liquid-filled capsule for clinical study in older children and adult asthmatic patients. Each capsule contains theophylline 150 mg. and glyceryl guaiacolate 90 mg. in polyethylene glycol. The recommended dosage was 1 to 2 capsules every six to eight hours.

Clinical Observations

A clinical study was carried out in 48 patients suffering from bronchial asthma. These patients ranged in age from seven to 68 years. The findings are shown in Table I. The capsules were used in the recommended dosage for the relief of acute asthmatic attacks or continuously in several patients suffering from chronic persistent bronchial asthma. Thirty-six of 48 patients (75 per cent) had good to excellent results (Table II).

It was evident that this preparation was especially useful in mild and moderate attacks of asthma and was particularly helpful when given early in the attack for relief of both coughing and wheezing. For more severe and persistent attacks, additional symptomatic treatment may be required. These measures, including epinephrine hypodermically, antibiotics, and short-term steroid therapy have been reviewed adequately in many publications.

Side effects were minimal. Five patients were nauseated, some only slightly. Patient 10 felt that the

TABLE I. CLINICAL RESULTS USING QUIBRON CAPSULES IN THE TREATMENT OF BRONCHIAL ASTHMA

Case No.	Patient	Age (yrs.)	Sex	Diagnosis	Dosage	Side Effects	Clinical Results	Rating
1	L.A.	56	F	A	1-2 q. 6-8 hr. p.r.n.	None	Very good—better than quadrinal	Good
2	S.B.	34	F	A	2 p.r.n.	None	Excellent and immediate relief	Excellent
3	W.B.	9	M	A	1 p.r.n.	None	No help	Poor
4	D.B.	31	F	A	1 t.i.d.	None	Helps very much	Good
5	B.C.	61	F	A Chr.	2 t.i.d.	None	Excellent "best yet"—off steroids	Excellent
6	T.C.	61	F	A	1 t.i.d.	None	Good	Good
7	E.C.	51	F	A & P.A.R.	1 q. 6 hr.	None	Good	Good
8	R.D.	33	M	A	2 q. 6 hr. p.r.n.	None	"Great" immediate relief	Excellent
9	K.D.	24	M	A	1 q. 6-8 hr. p.r.n.	None	Good—better than Tedral	Good
10	W.D.	52	M	A	1 p.r.n.	Sl. nausea	Excellent—"Like I.V. aminoph. and worth the slight nausea"	Excellent
11	J.E.	57	M	A	2 p.r.n. only	None	Very good	Excellent
12	E.F.	42	F	A	1-2 q. 6-8 hr.	None	Good but not as good as Tedral	Good
13	C.G.	38	F	A	2 q. 6 hr. p.r.n.	None	Good but liquid Quibron was faster acting	Good
14	T.G.	12	M	A P.A.R.	1 p.r.n. for A or cough	1 None 2 Excitation	Excellent, stops cough	Excellent
15	E.G.	44	M	A Chr.	2 t.i.d.	None	On continuous steroids. Helped at first	Poor
16	M.G.	41	M	A Chr.	1 q. 6-8 hr., 2 if very severe	None	Good	Good
17	M.J.	25	F	H.F. & A	1-2 p.r.n. q. 8 hr.	None	Excellent for asthma. No effect on hay fever	Excellent
18	C.J.	55	M	A P.A.R.	1-2 q. 6-8 hr.	None	Good for asthma No effect on P.A.R.	Good
19	R.J.	47	M	A	1 q. 6-8 hr.	None	Good to excellent	Good
20	C.J.	51	F	A Chr.	2 q. 6-8 hr.	Nauseated	Temporary relief	Poor
21	W.K.	58	M	A Chr.	1-2 t.i.d.	None	Excellent, immediate relief	Excellent
22	R.K.	12	M	A	1 q. 6 hr.	None	Poor	Poor
23	H.L.	47	F	A Chr.	1 q. 8 hr. or p.r.n.	None	Immediate relief. Better than Tedral S.A.	Excellent
24	E.L.	14	M	A	1 H.S. & p.r.n.	None	Helps fair	Poor
25	J.L.	52	M	A Chr.	2 p.r.n.	None	Good	Good
26	H.M.	54	M	A	1-2 p.r.n.	None	Excellent, immediate relief	Excellent
27	M.M.	35	F	A Chr.	1-2 p.r.n.	None	Very slow acting	Poor
28	S.M.	16	M	A Chr.	1 q.i.d.	None	Helped—better than Tedral	Good
29	W.M.	12	M	A	1 q. 6-8 hr.	None	Good	Good
30	R.M.	16	F	A	2 p.r.n.	None	Very good unless attack is ++++ then requires I.V.'s, adren., steroids, etc.	Excellent
31	J.N.	40	F	A Chr.	2 q. 6-8 hr.	None	Moderate relief (a very difficult and severe case)	Poor
32	E.P.	31	F	A Chr.	2 q. 6-8 hr.	1 Sl. nausea 2 more nausea	Not much relief (a very difficult and severe case)	Poor
33	H.R.	45	M	A	2 b.i.d.	None	Immediate relief	Excellent
34	P.R.	68	F	A	2 t.i.d. p.r.n.	None	Fast relief—excellent	Excellent
35	M.S.	58	M	A Chr.	2 p.r.n. then b.i.d. continued for 7 months	Sl. nausea and headaches disappeared in 5 days	"Terrific" better than Tedral. Stopped steroids	Excellent
36	D.S.	33	F	A	1 t.i.d. or q.i.d.	None	Good	Good
37	K.S.	7	M	A Chr.	1, 3-4 daily	None	Not as good as Tedral which caused bed-wetting and nervousness. Quibron caps work better than equivalent amount of liquid Quibron.	Good
38	A.S.	45	F	A	2 q. 6 hr.	None	Good	Good
39	R.S.	26	M	A—all his life	2 q.i.d.	Nauseated	Not as good as Tedral S.A.	Poor
40	B.S.	18	F	A	2 q. 6 hr.	None	Good—"nice relief"	Good
41	L.T.	42	F	A	2 q. 6 hr.	None	"Good and fast"	Excellent
42	R.T.	44	M	A	2 q. 6 hr.	None	Poor	Poor
43	C.T.	28	F	A	2 q. 4-6 hr.	None	Fair—slow relief	Poor
44	D.T.	49	M	A	1-2 p.r.n.	None	Good	Good
45	S.W.	56	F	A	2 q. 6-8 hr.	None	Poor	Poor
46	J.Z.	42	F	A	1-2 q. 6-8 hr.	None	Good	Good
47	D.M.	12	F	A Chr., steroids on and off	1 q. 6-8 hr.	None	Good. Stops wheeze better than Tedral and faster	Good
48	J.D.	46	M	A	2 p.r.n. 3-4 times daily	None	Excellent—relieves in 15 minutes	Excellent

Abbreviations: A=asthma, H.F.=hay fever, P.A.R.=perennial allergic rhinitis, Chr.=chronic.

immediate relief "like intravenous aminophylline," was worth the slight nausea. Patient 35, a chronic asthmatic on steroids, felt slight nausea and headaches which cleared after five days. He has continued the medication for seven months without recurrence of side effects and with almost complete freedom from asthma, despite discontinuing steroids.

TABLE II. SUMMARY OF RESULTS

Excellent	15
Good	21
Fair	6
Poor	6
Total	48 cases

36 (75%) excellent or good.

Summary

Clinical studies were carried out using a new preparation of theophylline and glyceryl guaiacolate (Quibron®), in liquid-filled capsules. Thirty-six of 48 patients suffering from moderate to severe bronchial asthma obtained good to excellent results (75 per cent).

Side reactions were minimal, primarily slight to moderate nausea, occurring in five patients. Two of these continued the medication since the relief obtained outweighed the side reactions produced. In one of these patients, the side reactions disappeared with continuation of the treatment.

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470 Fisher Building

THE VALUE OF DIGITAL PLETHYSMOGRAPHY IN DETECTION OF ARTERIAL DISEASE IN THE LOWER EXTREMITIES

(Continued from Page 1197)

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Acute Hemiplegia from Metastases in a Patient With Three Primary Malignancies

W. S. Reveno, M.D.
A. R. W. Climie, M.D.
H. Rosenbaum, M.D.
Detroit, Michigan

THE CASE to be described is of interest from two aspects. The occurrence of three discrete primary malignancies within four years is not common, and the association of laryngeal and pulmonary carcinomas is assuming increased significance.[1,2,4]

Clinically, exceptional causes underlying cerebrovascular accidents occur often enough to deserve diagnostic consideration. Prominent among these are unsuspected intracranial tumors that are known to cause misinterpretation of neurological disturbances.[3] In this patient, the development of acute hemiplegia with contralateral 3rd cranial nerve paralysis (Weber's syndrome) was due to cerebral metastases from one of the three primary malignancies.

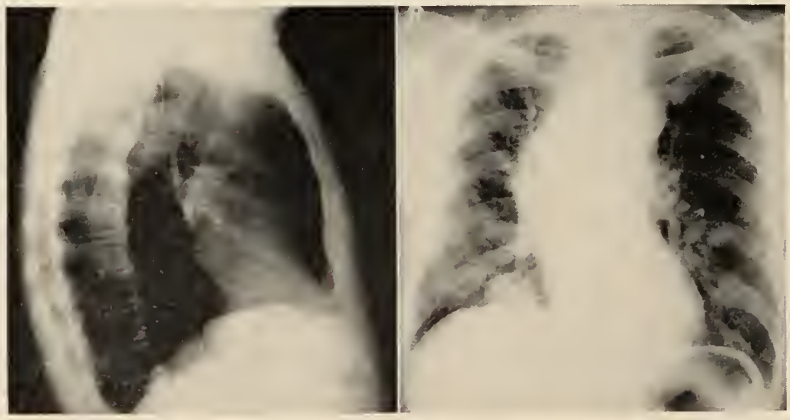


Fig. 1. *(left)* Chest radiograph at time of laryngectomy showing oval density. *(right)* Chest radiograph showing bilateral nodular metastases.



Author
W. S. REVENO, M.D.

Case Report

This 69-year-old white man, a heavy cigarette smoker and drinker for many years, fell on his way to the bathroom early in the morning of March 21, 1962, then got up, continued on his errand and returned to bed. During the next two hours, he was dizzy, had a splitting headache and became increasingly restless. He tried to arise but fell because his legs were weak. Past history included local excision of a superficial squamous cell carcinoma of the penis in 1958 and a laryngectomy for squamous cell carcinoma in December 1961. He had noted dragging of his left foot

From the Departments of Medicine and Pathology, Harper Hospital and Wayne State University College of Medicine, Detroit.

since recovery from the laryngectomy. A chest radiograph at the time of the laryngectomy (Fig. 1) was reported as showing negative findings, although an oval density, thought to be a lymph node, was seen in the mediastinum on the lateral view (right). On admission to the hospital, he was conscious and responsive, though unable to talk because of a permanent tracheostomy. Blood pressure, 210/114 mm Hg.; pulse, 76; temperature, 97°F.; respiration, 24/min. He was pale and thin, and there were bruises on both knees and the left shoulder. The left pupil was constricted and the right dilated and non-reactive. The right eyelid was closed and could not be opened voluntarily. The right fundus showed several small retinal hemorrhages on the nasal side of the disc. The tongue protruded in the midline. There was a tracheostomy opening just above the suprasternal



Fig. 2. Squamous carcinoma of penis showing early invasion. H and E x 23.

notch. The heart action was forceful with an occasional premature contraction and there was a harsh Grade II systolic murmur. The abdominal solid organs were not palpable. The abdominal and cremasteric reflexes were absent, and the left leg was flaccid. The left hand grip was weak. The plantar response was strongly extensor on the right with accompanying clonus; it was only mildly extensor on the left. Lumbar puncture showed an opening pressure of 420 mm water and a closing pressure of 220 mm. The fluid was under pressure, slightly cloudy, xanthochromic at first, then becoming grossly bloody. There were 17,900 erythrocytes, 220 polymorphonuclears and 11 lympocytes per cu. mm. The Colloidal Gold curve was 1112100000. The chlorides were 731, sugar 110 and protein 554 mg. per cent. Other laboratory studies were as follows: the urine had a specific gravity of 1.025 with numerous hyaline and granular casts in the sediment and a 4 plus albuminuria. The blood hematocrit was 42.5 per cent, hemoglobin 13.8 gm per cent, white blood count 20,700/mm^3 with segmented neutrophils 77 per cent, bands 7 per cent, lympocytes 14 per cent and monocytes 2 per cent.

The next day he appeared quietly asleep but responded promptly on being aroused. The flaccidity of the left arm and leg was unchanged, the right plantar reflex was still strongly extensor, and the deep reflexes were increased on both sides. On the third day, he was less responsive. The tongue now deviated to the right and the anisocoria was gone. The blood pressure was 150/90 mm Hg. Intravenous feeding was started. He became more responsive on the tenth day and after 14 days began to move the left hand. The left leg, however, remained flaccid with no plantar response for an additional two weeks. Then voluntary movement suddenly appeared and increased rapidly so that the patient could be moved by wheel chair for physical

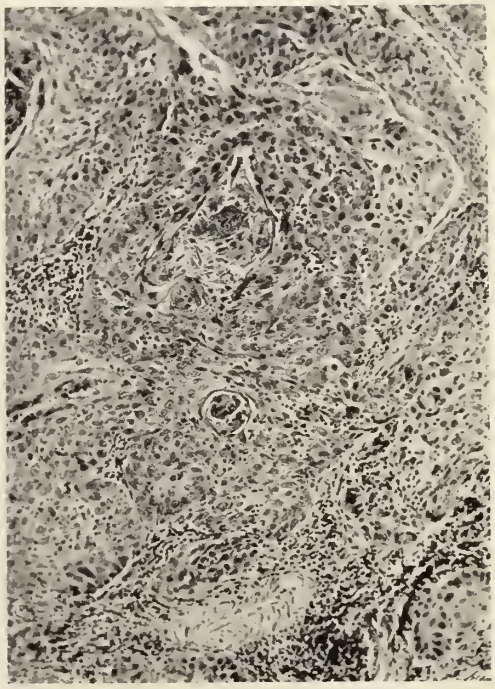


Fig. 3. Squamous carcinoma of larynx showing considerable keratinization. H and E x 144.

therapy. At the end of the seventh week, when there was only moderate left hemiparesis, scleral jaundice was noted for the first time. The liver edge was hard, nodular, tender and extended 4 cm. below the right costal margin. Laboratory studies were as follows: The serum transaminase was 66 units, bilirubin 6.0 mg. per cent (4.2 mg. per cent direct), cholesterol 140 mg. per cent, alkaline phosphatase 26 K-A units and the cephalin flocculation 3 plus at 24 hours and 4 plus at 48 hours. There was a leukocytosis of 11,100/mm^3 with segmented neutrophils 74 per cent, bands 8 per cent, lymphocytes 9 per cent, monocytes 5 per cent, eosinophiles 3 per cent and basophiles 1 per cent. A chest radiograph showed bilateral nodular metastases of hematogenous type in both lungs (Fig. 1 b). There were also believed to be metastases in the hilar and mediastinal lymph nodes. The oval density originally tagged as a lymph node was now thought to be a metastasis. The patient steadily deteriorated, became anxious, restless and developed labored breathing. He died quietly on May 16, eight weeks after the acute cerebrovascular accident.

Pathology

Surgical Specimens:

Penis (1958).—The lesion was an ulcer on the skin of the penis measuring 3x2cm. The edges were raised and the base was red and granular. Microscopically, the squamous epithelium was ulcerated in the center with under-

lying inflammatory granulation tissue. The surrounding epithelium was thickened and demonstrated predominantly intra-epithelial carcinoma with a few areas of micro-iinvasion of the dermis (Fig. 2).

Larynx (1961).—The lesion in the larynx arose in the left false vocal cord and extended to the true cord. The tumor measured 3x1cm. and demonstrated an ulcerated and

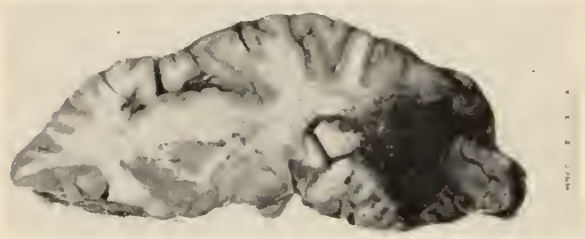


Fig. 4. Horizontal section of brain showing metastasis in right occipital region with associated hemorrhage.

fungating surface. Microscopically, the lesion was a typical squamous carcinoma, well differentiated near the surface and considerably more anaplastic in the deeper portion (Fig. 3). There was no extra-laryngeal extension.

Necropsy (1962).—The right lung weighed 820 gm. and showed diffuse involvement of the upper lobe with firm whitish-yellow tumor tissue. The tumor surrounded the main stem bronchus and the branches leading to the upper and middle lobes, the entire mass measuring 13x6x5cm. Nodules of tumor projected into the lumen of the main bronchus and gave the impression that the lesion originated here. Discrete nodules of tumor were present in the middle and lower lobes of the right lung and throughout the left lung. Metastatic deposits were located in the liver, spleen, left kidney, left adrenal and mediastinal and cervical lymph nodes. The posterior tip of the right occipital lobe of the brain was the site of a tumor nodule 3 cm. in diameter. The tumor was partially necrotic and hemorrhagic with extension of the extravasated blood to the surface and into the subarachnoid space (Fig. 4). Another metastasis, 2 cm. in diameter, was seen more anteriorly in the white matter adjacent to the lateral ventricle. Necrotic tumor extended into the ventricular cavity from this lesion. There was no evidence of uncal or brain stem herniation.

Microscopically, the lesion in the lung was a relatively well differentiated adnocarcinoma (Fig. 5). Necrosis was a striking feature of the primary and most of the metastases, all of which were adenocarcinomatous in type. Zones of infarction surrounded the cerebral metastases and extravasated blood was visible both within the tumor and in the areas of softening. No residual or metastatic squamous cell carcinoma was discovered.

Discussion

This patient developed three discrete carcinomas within a period of four years. The squamous carcinoma of the penis was localized and predominantly intra-epithelial with only microscopic areas of invasion. Surgical removal resulted in cure with no residual present at autopsy. Of more interest is the association of the laryngeal and pulmonary carcinomas as similar cases have been reported with increasing frequency and several sizable series are on record. Hollinger's[2] article describing this association in 16 cases was soon followed by additional reports by Perez[4] (11 cases) and Cahan[1] (60 cases). Combining figures from these publications, it is apparent that in 62 of the 87 cases the carcinomas were discovered synchronously. Of the remaining 25 patients, in whom the diagnosis was made metachronously, only six developed the pulmonary carcinoma first. This is not surprising as there is general agreement that survival is dependent on the rate of growth and spread of the pulmonary lesion.

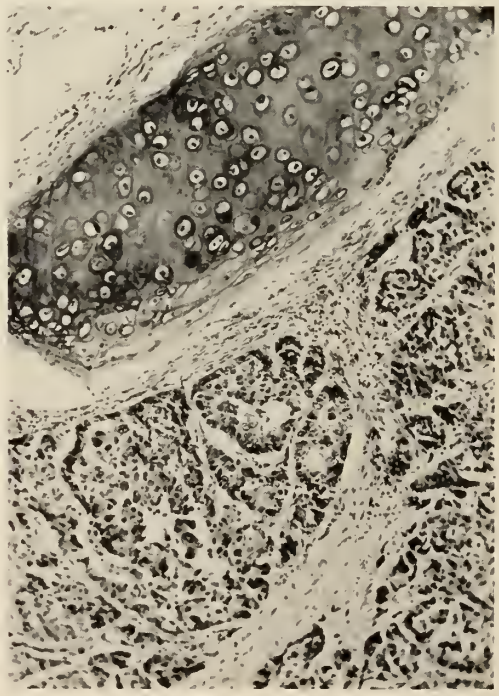


Fig. 5. Adenocarcinoma of lung in bronchial wall. H and E x 112.

Many individuals, therefore, probably die from bronchogenic carcinoma who conceivably would have developed laryngeal carcinoma had they lived. In only seven cases was the pulmonary neoplasm an adenocarcinoma as in the present case. This histologic type bears no relation to smoking history in contrast to both laryngeal carcinoma and bronchogenic carcinoma of the squamous variety.

In seven of 60 patients in Cahan's series, the laryngeal and pulmonary carcinomas were two of three separate primary malignancies as in the case reported here.

Although it is not difficult for a competent patholo-

gist to determine whether a laryngeal tumor is primary or not, the fortuitous development of bronchogenic adenocarcinoma in our case eliminated any possibility of the larynx being involved by a metastasis from the co-existing pulmonary neoplasm, and of the cerebral metastasis originating from the laryngeal lesion.

The ipsilateral paralysis of the oculomotor nerve and contralateral hemiplegia seen in this patient is characteristic of Weber's syndrome which is most commonly due to a lesion of the cerebral peduncle where the oculomotor nerve and pyramidal tract lie in close approximation. In retrospect, it is quite likely that the weakness of the left leg noted three months prior to admission was the first manifestation of cerebral metastases. These must have been present at that time causing displacement of the edge of the tentorium cerebelli against the right cerebral peduncle. The sequence of events leading to the acute cerebrovascular accident probably originated in a temporary nipping of the right posterior cerebral artery by the edge of the tentorium resulting in ischemic softening of the brain in the occipital lobe. When, for some reason, the extrinsic pressure on the artery was temporarily released the rush of blood caused hemorrhage into the area of encephalomalacia. The resultant increase in intracranial pressure was again sufficient to compress the free edge of the tentorium against the mid-brain with development of Weber's syndrome.

Summary

A patient with three discrete primary malignancies developed an acute hemiplegia from hemorrhage into and around a cerebral metastasis. The primary source was a pulmonary adenocarcinoma. The other primary lesions were a squamous cell carcinoma of the penis discovered four years before the cerebrovascular accident and a squamous cell carcinoma of the larynx detected three months before.

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HYALINE MEMBRANE SYNDROME

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Medical Arts Building
Tenth and Court
Port Huron, Michigan

Optimum Minimum Dose of Tolbutamide In Geriatric Diabetic Patients

Jack F. Sanders, M.D.
Alma, Michigan

This study indicated that the currently commonly employed dosages and increments of dosage of tolbutamide in geriatric diabetic patients are far too large. Almost all responsive geriatric diabetic patients can be controlled and maintained on 500 mg. to 1000 mg. of tolbutamide in divided doses.

ORAL hypoglycemic agents have come into common usage rapidly in the past five years for the control of diabetes mellitus in the geriatric patient. One of the reasons for the employment of the oral hypoglycemic agents has been their relative ease of administration as compared to the time consuming and difficult job of persuading the patient to accept insulin and teaching him or a member of his family how to administer it. Fortunately, the oral hypoglycemic agents have been effective in a large percentage of the geriatric diabetic patients, particularly as measured by fasting blood sugars, and with minimal side effects or toxicity. In our patients at the Michigan Masonic Home and Hospital during the past three years, more than 80 per cent of 105 diabetic patients have been controlled and maintained with good control, and with less than 5 per cent per year of secondary failures. All failures, primary and secondary, have been maintained on insulin; three have required regular crystalline insulin three times a day, the rest have been controlled on Lente or NPH insulin in doses ranging from 8 to 30 units daily; one has been uncontrollable. Perhaps the reason for the high percentage of primary controls as compared to other series reported in the literature[5] (80 per cent here as compared to 60 to 70 per cent in most reported series) is due to the higher age group represented here and its homogeneity. Our patients averaged 83 years at the start of the study with a range of 70 to 95 years.

As nearly as we can observe, the common practice in this area of Michigan for initiating tolbutamide therapy has been to use variations of the schedule as outlined in the tolbutamide brochure. One suggested schedule for beginning therapy is: 3 Gm. (6 tablets) on the first day, 2 Gm. (4 tablets) on the second day, 1 Gm. (2 tablets) on the third day, and 1 Gm. (two tablets) on the fourth and subsequent days with increase or decrease as necessary to control glycosuria. Most of the geriatric diabetics in this area are maintained indefinitely on at least 1.5 Gm. (3 tablets) to 2.0 Gm. (4 tablets) per day, usually in divided doses.

"The ideal dose is the smallest amount which will maintain optimum control."[2] Two questions particularly come to mind. First, is it necessary, or is there any advantage in using doses as large as those commonly suggested and in common use? Second, is the optimum or ideal increment of dosage the standard 0.5 Gm. tablet, or would a smaller increment, such as 0.25 Gm., or some other increment be more optimal? In addition to the obvious clinical advantages of using the smallest dose which will maintain optimum control, there is an advantage of cost to the patient in using the smallest optimum dose.

Methods

All of the patients in this study were residents of the Michigan Masonic Home and Hospital, Alma, Michigan. Because of the "captive population" living pattern, it was fairly easy to follow the patients on a day-to-day basis. All were untreated diabetics, newly diagnosed after their admission here. Their meals were all taken at special diabetic tables with menus supervised and measured by a dietitian. The standard diet was 80 grams protein, 70 grams fat, 210 grams carbohydrate for a total of 1800 calories, with adjustments to as high as 2400 calories for those who required

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Doctor Sanders is Medical Director, Michigan Masonic Home and Hospital, Alma, Michigan.

more for their energy expenditures and body weight maintenance. All patients were followed for a minimum of four weeks prior to initiation of medication to insure stability of weight and adequacy of diet and nutritional state. A detailed history and physical examination with special emphasis on noting evidence of diabetic complications such as neuropathy, nephropathy, retinopathy, peripheral vascular insufficiency and coronary insufficiency was made on each patient. All had three-hour oral glucose tolerance tests of grossly diabetic pattern. Interestingly, none of the patients in this study group evidenced glycosuria except during peak levels of their glucose tolerance tests or post-prandially. Renal threshholds were consistently above 200 mg. per cent.

Because of the difficulty in defining diabetes mellitus in geriatric patients, only those patients who were unquestionably diabetic were included in this study. In studies elsewhere (Gottfried at the Masonic Charity Foundation, Wallingford, Connecticut)[7] and in similar studies done here, almost 100 per cent of persons in the 70 to 95 age group have abnormal glucose tolerance curves in terms of the standards applied to young and mature adults. To be certain that this study included only unquestioned diabetics, and excluded "normal delayed glucose tolerance response of the aged," and pre-clinical or subclinical or "mild" diabetics, the following somewhat arbitrary criteria were utilized:

> Fasting blood glucose determined at least three times weekly prior to any drug treatment shall be:
>
> (a) Greater than or equal to 100 mg. per cent, and
> (b) Consistent in range; e.g., 95 to 115 (105 ± 10),
> (c) For at least three weeks prior to beginning drug therapy.
>
> All glucose tolerances showed two-hour levels of 200 mg. per cent or greater and three-hour levels in excess of 150 mg. per cent, as measured by 100 Gm. oral glucose tolerance tests.

Tolbutamide therapy was initiated with 250 mg. at breakfast. Fasting blood glucose levels were determined three times per week throughout the study. This dosage was maintained until:

> (a) Blood glucose level had shown no change for three weeks, or
> (b) Blood glucose level had decreased and stabilized at the new level for at least two weeks.

Incremental increases in tolbutamide therapy were 250 mg. according to the same criteria as above.

Good control was defined for purposes of this study as being evidenced by fasting blood glucose levels of less than 90 mg. per cent consistently.

When good control had been achieved, the dosage was backed off at three to four week intervals by the same 250 mg. increments in an attempt to maintain control at a dosage not to exceed 250 mg. b.i.d.

Thirty-five new diabetics were studied and screened for this study. Nineteen were followed for one year with tri-weekly blood glucose determinations as noted above. The rest were dropped from the study because they did not meet all of the criteria arbitrarily set up for this study, although they are being followed as diabetics and most of them are being maintained on tolbutamide.

Blood glucose determinations were done in the Upjohn Laboratories at Kalamazoo, Michigan. Specimens were drawn at 7:00 a.m., heparinized, quick frozen, and shipped frozen to the Upjohn Laboratories for determination on the Auto-Analyzer.[3]

Results

Fifteen of the 19 patients achieved good control; eight on doses of 250 mg. of tolbutamide b.i.d. and seven on doses of 500 mg. Four of the patients were failures.

One man (HM) dropped from a pre-treatment fasting glucose level of 200 mg. per cent to an average of 118 mg. per cent after four weeks on 250 mg. of tolbutamide b.i.d., breakfast and supper. Four weeks of 500 mg. b.i.d. failed to reduce his fasting blood glucose levels any further. During the next four weeks on 750 mg. b.i.d., his blood glucose gradually rose to 160 mg. per cent. He died 72 hours after a cerebrovascular accident with right hemiplegia and aphasia. One woman (GC) with pre-treatment fasting levels in excess of 300 mg. per cent dropped to an average of 230 mg. per cent after four weeks on 250 mg. of tolbutamide b.i.d. However, she felt weak, was losing weight, and developed an upper respiratory infection. She was changed over to insulin and has been maintained since on Lente insulin 30 units every morning with fasting blood glucose levels of 112 mg. per cent. One woman (MV) with pre-treatment fasting levels over 300 mg. per cent showed no response on 250 mg. b.i.d. for four weeks; after four weeks more of 500 mg. b.i.d., she dropped to an average of 274 mg. per cent of glucose; she showed no further drop on 750 mg. b.i.d. for four more weeks, and no drop on 1.0 Gm. b.i.d. Attempts have since been made to control her with insulin. Her fasting blood glucose still varies between 260 mg. per cent and over 300 mg. per cent, despite regular crystalline insulin to as much as 150

units in divided doses, combinations of insulin, and combinations of insulin with tolbutamide and insulin with chlorpropamide. One woman (BS) with pre-treatment levels of glucose averaging 158 mg. per cent dropped to an average of 125 mg. per cent, but has fluctuated without obvious reason between 110 and 176 mg. per cent on doses of tolbutamide b.i.d. of 250 mg. and 500 mg. She possibly would be a candidate for combined insulin therapy, but she refuses insulin. Three patients (DC, FL, JT) reduced their fasting blood glucose levels on 250 mg. of tolbutamide at breakfast only, 269 to 167, 152 to 117, 130 to 106, and all three dropped below 90 mg. per cent on 500 mg. of tolbutamide b.i.d. The remaining 12 patients reduced their fasting blood glucose slowly and consistently over an eight-week period on 250 mg. of tolbutamide b.i.d.; four of them required 500 mg. b.i.d. to reduce their fasting blood glucose levels below 90 mg. per cent; eight did so on 250 mg. of tolbutamide b.i.d.

Attempts were made gradually to decrease the dosage of the seven patients who required 500 mg. of tolbutamide b.i.d. initially to reduce their fasting blood sugars below 90 mg. per cent. It was possible to reduce one of the seven to 250 mg. of tolbutamide t.i.d., 750 mg. total daily dose; but the other six could not be reduced below a dosage of 500 mg. b.i.d.

Near the termination of the study after all patients had evidenced stability for at least eight weeks, all patients were discontinued from tolbutamide for three weeks. None of them showed any significant change in blood glucose for two weeks. Half of them were in poor control range with fasting blood glucose levels in excess of 150 mg. per cent at the end of three weeks, and all of the other half except one showed rises of 30 mg. per cent or more at the end of three weeks.

Of our other present 63 diabetics (not part of this study) in the Home and Hospital, 10 receive insulin, three are maintained on chlorpropamide they were taking on arrival, and 47 are maintained on tolbutamide. Of the 47 on tolbutamide, 35 are on 250 mg. b.i.d. and 12 on 500 mg. b.i.d. Their control is considered acceptable if they remain in the 90 to 115 mg. per cent glucose range; two thirds of them (32) fall into this range, one-fifth of them (10) remain in the 116 to 130 mg. per cent range; the remaining 10 per cent (five) are poorly controlled but are continued on oral hypoglycemic agents as a compromise because of their failure to cooperate, either by refusal to consider insulin or other therapy, or by willful dietary indiscretions.

Hemoglobins, hematocrits, red blood cell counts, BUN's, weights $\pm$ 5 lbs., remained stable in the study group during the year. All but one of the patients had moderately elevated BUN's in the 21 mgm. per cent to 35 mgm. per cent range throughout the study. There were several URI's in the study group. Two suffered fractures, one both bones of the forearm, one a hip which was nailed the next day. None of the intercurrent episodes affected the fasting blood sugars appreciably. Except for patient GC, there were no complications requiring supplemental insulin therapy. There were no occasions of ketonuria or acidosis.

Discussion

On the basis of this study of 19 aged new diabetic patients, we believe that the majority of aged new diabetics can be controlled on much smaller doses of tolbutamide than those currently commonly employed. This could be a very important factor in obtaining cooperation and consistent follow-through by patients. Where economic considerations are important to the patient, it may mean the difference between his cooperating in a good control program and his shaving it a little here and there and even totally interrupting his medication periodically. The cost of oral hypoglycemic agents is almost prohibitive to many of the limited budget geriatric patients. It is physically much easier to swallow one half or one tablet than it is to take two or three at a time; one of the common patient objections to the tolbutamide programs is that they find it difficult and objectionable to take so many tablets at one time. On the larger doses, a few patients experience vague gastro-intestinal distress and anorexia. The pharmaco-physiologic reasons for using the smallest optimum dose hardly need reiterating.

Inasmuch as only three patients lowered their fasting blood glucose levels significantly on 250 mg. of tolbutamide once daily, and none of the three achieved optimum control on this dosage, it would appear that 250 mg. of tolbutamide b.i.d. is about the lowest dosage that will be likely to achieve control, and that in only about one-half of responsive patients. On the basis of this small group, there are probably very few occasions where a dosage of 500 mg. b.i.d. need be exceeded. Of the 15 patients in whom we were able to obtain control, none required more than 500 mg. b.i.d. of tolbutamide.

One-half and quarter fractions of the standard 0.5 Gm. tablet appear to be a fine enough division of incremental doses for all practical purposes, and there would be little value in trying to establish an increment in some odd or unusual value such as, 67 mg. or 132 mg.

In this age group, there appears to be little virtue in starting with a large dose of tolbutamide and then gradually decreasing it. While it was not done on the 19 patients in the year-long study group, we have recently tried in 12 other new aged diabetic patients to alternate beginning treatment according to the suggested schedule in the tolbutamide brochure as noted above, beginning with 250 mg. b.i.d. and increasing incrementally as needed. There was no significant difference in the rapidity of obtaining control; there were more subjective complaints in the more vigorously treated patients, particularly vague gastro-intestinal distress and anorexia, and mild symptoms suggestive of hypoglycaemia.

It takes six to eight weeks for the responsive aged diabetic to obtain optimum control and stability on a given dose of tolbutamide. Dosage should not be juggled repeatedly during the early stages of treatment.

The persistence of tolbutamide effect on withdrawal after stability has been achieved would argue for the concept that tolbutamide effect is due to islet cell stimulation.[3]

Glycosuria is of little or no value in diagnosing diabetes in the aged nor in the control of dosage of hypoglycemic agents, either oral or insulin, because of the high renal threshold almost invariably present in these patients.

Conclusions

Fifteen of 19 aged new diabetic patients were controlled optimally on doses of tolbutamide not exceeding 500 mg. b.i.d. One-half of them were controlled on 250 mg. b.i.d. The currently commonly employed dosage schedules would appear to be far higher than are necessary in this age group. Smaller doses effect better patient cooperation and also economic savings. Dosage increments of 250 mg., one-half of the standard scored 0.5 Gm. tablet, are flexible enough for practical purposes.

Acknowledgments

This work was made possible by a grant from the Upjohn Company which supplied the tolbutamide and performed the glucose determinations. I received invaluable cooperation and assistance from Anne Valkenier, my laboratory technologist, and from the nursing personnel and the dietary department of the Michigan Masonic Hospital.

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The First Step Toward Socialization

Pennsylvania Medical Journal, Vol. 66, No. 5

"Socialized medicine will come here unless the doctors, dentists, osteopaths, businessmen, and all people who are interested in remaining free join together from the beginning to defeat it," according to a former Saskatchewan, Canada, physician now in Pennsylvania.

Robert M. Ruthven, M.D., now on the Warren State Hospital staff, told a meeting of the Warren County Medical Society, Pennsylvania, that his impression of the Fedicare plan in the United States is that it is simply the first step in socializing the entire United States economy.

He said: "If the doctors of this country are to prevent the socialization of American medicine, they must enlist all the professions in the fight and do it now."

Doctor Ruthven remarked that there is little justification for the drive for Fedicare since the 9 per cent of the American population over sixty-five has 8 per cent of the total income of the country.

Editorial Comment

Osteopathic "University" in State?

How to Waste Money!

(*The Detroit News*, November 17, 1963)

The announced proposal of the American Osteopathic Association and the Michigan Association of Osteopathic Physicians and Surgeons to establish an osteopathic "university" somewhere in Michigan is vague, wasteful, divisive, and lacking in wisdom and foresight.

The prospect of having a $35 million institution, including a 600-bed hospital, which would provide jobs for some 2,000 employes, naturally has many Michigan communities more than merely interested.

But before these communities start adding up the economic benefits involved, it might be well to find out exactly where the $35 million would be coming from. The University promoters are vague about this, but it seems apparent that local support is expected to be an important factor. Michigan's two existing medical schools are supported by state taxes. The University of Michigan medical college has an annual budget of more than $13 million and its total Medical Center one of some $30 million.

When such sums for operation of an osteopath "university," with an adjoining hospital, are added to the $35 million in capital costs for the creation of such institutions the problem confronting the osteopaths becomes formidable.

But even if all these millions could be found and the sources available for future years guaranteed, the proposal would still be wrong.

What the osteopaths are attempting to supply could be supplied in a more economic and satisfactory way through other means.

The five present osteopathic colleges in the United States are not themselves in strong financial condition. None of them is associated with a university, a school of public health, a department of psychology or of sociology. There is not a complete medical center within the whole national osteopathic system and there is no genuine facility for advanced training in highly specialized work.

The colleges are, however, satisfactory as far as they go and, if their graduates were to attend postgraduate medical schools, the results could be practitioners with a sufficient depth and breadth of knowledge and skill to become well-rounded doctors.

Some osteopathic hospitals are the equal of some medical hospitals, but this is a comparison of their best with medicine's poorest. Osteopathy cannot provide a hospital the equivalent of Harper, Henry Ford, Receiving, Grace, or the University of Michigan, to use local examples, or of Massachusetts General or Johns Hopkins to go further afield.

Osteopathy is parasitic in the sense that it does not produce graduate nurses, physical and occupational therapists, medical social workers, dietitians, medical librarians, medical technologists, and the like.

These are produced under the existing medical education system. Medical knowledge produces the very textbooks and other written tools of the osteopath and it is medical research that is used by osteopaths in advancing their own skills.

The point here is that this is the way that it should be. Parallel systems of medical education and post-medical school research are economically wasteful.

They are divisive—as the projected "university" would be divisive—when what is needed and what is gradually happening is that the osteopaths and the medical doctors are getting closer and closer together.

California osteopaths saw the light and 90 per cent joined the medical profession in order to enjoy the benefits of postgraduate training.

Michigan osteopaths by proposing grandiose institutions for the perpetuation of a schismatic limited form of medical treatment are sabotaging a desirable trend, one that is in the interest of the public they serve.

The economic facts of life may be sufficient to persuade all but those few with vested interests to forget their dream, abandon the proposal, and work toward a unified upgraded profession.

Medical care is costly enough without burdening it with twin systems where one will do the job and do it better for all concerned.

Ever Wiser

Knowledge, wisdom, and the pursuit thereof characterize the modern American physician. It has been said that the physician who fails to continue his own education becomes obsolete within ten years after his graduation from medical school and this is probably true.

However, it is a difficult thought to test, since one is hard put to find an obsolete physician. Thanks for this scarcity belongs in no small part to organized medicine in the United States. Although our activities in politics and economics draw more headlines, our activities in continuing and postgraduate medical education represent one of the founding purposes for organized medicine and one of the truly great accomplishments.

In the State Society section of this issue, John M. Sheldon, M.D., Chairman of the Michigan State Medical Society Postgraduate Education Committee, reports impressive data with reference to Michigan's leadership in postgraduate education. His report is properly a source of pride and satisfaction for the physicians of our State.

Congratulations

THE JOURNAL notes with pride the recent appointment of Ernest Gardner, M.D., as Dean of the Wayne State University College of Medicine. Doctor Gardner received his Doctor of Medicine degree from Stanford University in 1941 and has a broad experience in medical education, having served on the faculties at Stanford University, the University of Southern California and Wayne State University. He has served as Professor and Chairman of the Department of Anatomy at Wayne State University since 1950 and was Associate Dean prior to his promotion to the office of Dean. In addition to his effective understanding of problems in clinical medicine, he is a distinguished investigator and scientist in his own right with



ERNEST GARDNER, M.D.

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special interests in the anatomy and physiology of joints and in neuroanatomy and neurophysiology.

Michigan looks forward to inspired leadership from Doctor Gardner as Wayne State University's College of Medicine continues its rapid pace of growth and development in the future.

Money and Medical Manpower

We are all aware that there has been a progressive decline in the number of applicants to medical school over the last fifteen years. Many reasons have been advanced for this fact, usually focusing on the "deterrents to medical education." These include the time required for a medical education, the cost thereof, the increased attractiveness of other professions, the relative opportunity for a medical education and the rapid rise of competing opportunities.

There is much talk about shortening the length of the time required for a medical education. As a matter of fact, the actual medical curriculum at The University of Michigan Medical School has not been increased for 73 years! However, the amount of material that must be covered in the four years of formal medical education has increased astronomically. While the calendar length has not increased, a progressively greater utilization of the time in those four calendar years has occurred. The actual lengthening of the time required for a medical education has occurred in the period after the internship.

Even so, we believe that the basic problem involved is not the length of the period of education but, rather, *the length of the period of starvation.* For this reason, we must anticipate a much more realistic level of compensation for interns and residents. This is, in fact, the current trend. It is in the period of postgraduate training that medical education has been lengthened and that the sociologic impact, as well as the economic one, has been so clearly seen. The resident physician today is usually married and better than half the time has started a family. He has borrowed money during medical school and he finds it progressively difficult to continue to borrow through his residency training. For many years, the intern and resident have been the forgotten men insofar as the availability of loan funds and fellowships are concerned. It was into this gap that organized medicine moved with the formation of the Medical Education Loan Guarantee Program which is open not only to medical students but also to interns and residents. As of June 1963, almost 1½ million dollars had been contributed for the Loan Guarantee Fund, making a bank credit of over $18 million available, of which $15 million has already been extended. These are large numbers but come close to home when we find that 249 loans totalling $287,600 had been made to borrowers in the State of Michigan in the sixteen months of existence of the program. Fifty-eight medical students at The University of Michigan borrowed $62,100 and 69 medical students at Wayne State University College of Medicine borrowed $77,600, while 142 interns and residents obtained loans in the State of Michigan.

Loans, secured by $1 for each $12.50 worth of credit have averaged $1,120 in principal amount. The minimum that can be borrowed is $400 and the maximum is $1500 during any academic year. Loans to residents and interns have averaged slightly higher in the amount of principal than those to medical students.

It is of interest to note that there was an increase in applicants to medical school in 1962-63 for the first time in almost a decade. Much of the credit for this increase belongs to organized medicine for its programs of recruitment and for its program of economic support to the medical student and the physician in training. It is important that we continue to demonstrate the effectiveness of private enterprise and organized medicine in this fashion. Some have suggested that the Federal Government assume this entire reponsibility. Default on our part should never be available as a supporting argument for this thesis.

THE SPIRIT OF MEDICINE

By John M. Dorsey, M.D.

Detroit, Michigan

Body and soul are not two substances but one.
They are man becoming aware of himself in two different ways.
Von Weizsacker

Recently a justly renowned medical man* had occasion to speak of the "spirit of medicine." In favoring this expression, he was fully aware that he was allowing himself a fond excursion into his strictly personal and entirely individual realm of ideality.

A possible trouble with such evident recourse to ideality is that it may mobilize the disinterest of every auditor who needs to feel in close touch with his speaker, and who therefore may resent the latter's apparent withdrawal from him as rude rejection.

Since, as all else, every physician must solve and settle this matter for himself, I wish to record a statement of my concept of the spirit of medicine. Although I can conceive of myself as all sense, I also find that I can often live as if I have no sense at all.

For example, even though I see clearly that the consequence of my ignoring my individuality is madness, every day I find it exceedingly difficult (and sometimes impossible) to "hang on to myself."

By concentrating upon the whole truth of human individuality, Hippocrates discovered and recorded, "Nature is the physician of diseases." Every physician cherishes his unique self-development into a doctor of medical experience and proudly upholds his theory of physicianary helpfulness for its utmost *practicality*. His *spirit* of medicine issues directly from his spirit of life itself which provides his mind with its every meaning, his world with all of its wisdom. His spirit keeps him going strong "against odds," "uphill all the way," "in spite of everything." Unaccustomed as he may be to conceiving his medical profession as spiritual endeavor, nevertheless most of all he sees his spirit as his true self, as the very soul of his individuality, as the mover which is itself unmoved (Aristotle).

It comes natural to me in my profession as an M.D. to translate the language of spiritual living into terms of less evident subjective significance, for my patient as a rule speaks an idiolect which indicates greatly limited awareness of his real comprehensiveness. I must first be willing to try to speak his kind of language if I would have him try to learn the life-giving language of clearly evident self-experience. My greatest of all medical preparation for living the life of a physician is my unceasing cultivation of mind-consciousness. Without mind-consciousness I cannot grow my self-realization; and without my self-realization I cannot attribute self-importance to my fellowman.

There is nothing good or bad but thinking makes it so, sagely declared Shakespeare. In direct proportion to my appreciation of what it really means to be a human individual, I see that I enjoy *spirited* existence. My high estimate of my human creaturehood is ever associated with inspirational self-experience. My low estimate of my human selfhood is associated with dispirited living. Insofar as I enjoy awareness of my human power, I cherish my life and motivate myself to learn every kind of life-guarding medical lesson. Insofar as I suffer ignorance of my human power, I misprize the true wonderfulness of my life and really am unable to care for my well-being.

Whenever I recognize my mind's awesome power, I am glad to be alive, have the strongest hold on life, and enjoy myself *just as I am*. Then the extent of my ambition, the goal of my life, is to stay alive. Then I do not suffer that goad of ambition which is a thinly disguised complaining about my lack of sufficient self-appreciation. I do not chase after the mirage of progress, whenever I know that I am the mover and the unmoved.

What I am getting at is this: my idea of the Spirit Of Medicine is that it is specifically *the spirit of conscious human individuality*. All tolerance is self-tolerance; all intolerance is self-intolerance. My intolerance restricts the range of my conscious imagination, blocks the right-of-way for my conscious will, anaesthetizes my sense of wholeness of being, and appears even to trivialize the meaning for my life itself. My every tolerance extends the range of my conscious imagination, opens the right-of-way for my conscious will, animates my sense of wholeness of being, and illuminates the awe-inspiring meaning for my life itself.

For the significance of human individuality versus society it is indeed fair to consult the view of a soci-

*Dr. Thomas J. Heldt, referring to the singular high-spirited devotion of Editor Wilfrid Haughey, M.D., who now lives on lovingly in the life of each of his medical brothers.

ologist. Here is what Michigan's most insightful sociologist, Professor Charles Horton Cooley, has to say on that head:*

> I conclude that the imaginations which people have of one another are the *solid facts* of society, and that to observe and interpret these must be the chief aim of sociology. I do not mean merely that society must be studied by the imagination —that is true of all investigations in their higher reaches— but that the *object* of study is *primarily* an imaginative idea or group of ideas in the mind, that we have to imagine imaginations. . . . It is important to face the question of persons who have no corporeal reality, as for instance the dead, characters of fiction or the drama, ideas of the gods and the like. Are these real people, members of society? I should say that insofar as we imagine them they are.

Professor Cooley goes on to point out that it "is healthy for every one to understand that he is, and will remain, a self-seeker, and that if he gets out of one self he is sure to form another which may stand in equal need of control."

My theme is not that of exaltation of human individuality to the highest plane. For I see that the human individual is already the marvelous being of the most comprehensive order, ever fashioning his world out of himself. My one and only intention in this writing is to point out that my recognition of the inviolable integrity of sovereign human individuality has been the most helpful medical self-development of my experience to date. It gives me new and vital meaning for the rights of man, the excellence of man, the hygiene of man, and the divine spirit of the healing art.

It is ideally fitting here to quote the medical wisdom of that spiritually knowledgable German, Friedrich Nietsche.†

> Physician, help yourself: thus you help your patient, too. Let this be his best help that he may behold with his eyes the man who heals himself.

There occurred medical madness, and not so very long ago but that every M.D. now discharging his privileged and dangerous office can still feel its deep hurt without yet being able to grow the deep cheer to renounce it. My Nazi medical colleague, insufficiently aware of the awful truth of human individuality and insufficiently knowing of the true spirit of medicine, lived his unwilling and potesting patient for so-called military medical experimentation. Certain of my Michigan medical colleagues did follow-up work with me on several individual patients who were able to survive their excruciating medical experiences.

The cessation of the insanities of war permitted the discovery that the sacred dignity of human individuality had been finding no war-time sanctuary in medical or in any other kind of living. Following the initial shock over this terrifying truth, every effort was exerted to *fix responsibility* for military medical experimentation upon the inviolable human individual. There occurred a gradual awakening to the sobering fact that, without the comprehensive meaning of unique human individuality, there could be no fixing of responsibility.

Every M.D. is basically his own educator. I can speak for myself only. Now is the time for my every M.D. to apply the only *kind* force there is, education, to his cultivation of awareness of the comprehensive meaning of human individuality as being the only safe and sane basis for his comprehensive study and practice of medicine. My *spirit of medicine* is my medical ideal: A gain of self-appreciation for my patient is a gain of self-appreciation for me.

In 1948, The General Assembly of the World Medical Association conceived and adopted an already great historic document, the Declaration of Geneva.* It is recommended for consideration by every medical representative on every suitable medical occasion, being designed with the medical ideal of the spirit of human individuality specifically in mind. May it be found worthy of continued study in every medical office, as it is in mine.

Please note its solid reliance upon the personal words which permit the fixing of responsibility, by honoring individuality as being the only source of the spirit of humanity: "I" "my" and "me."

DECLARATION OF GENEVA

At The Time Of Being Admitted As Member of The Medical Profession:

I SOLEMNLY PLEDGE myself to consecrate my life to the service of humanity.

I WILL GIVE to my teachers the respect and gratitude which is their due;

I WILL PRACTICE my profession with conscience and dignity;

THE HEALTH OF MY PATIENT will be my first consideration:

I WILL RESPECT the secrets which are confided in me;

I WILL MAINTAIN by all the means in my power, the honor and the noble traditions of the medical profession;

MY COLLEAGUES will be my brothers;

I WILL NOT PERMIT considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;

I WILL MAINTAIN the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I MAKE THESE PROMISES solemnly, freely and upon my honor.

*Thanks to my good friend, Dr. Samson S. Wittenberg.

Human Nature and the Social Order, pp. 121-122, Charles Scribner's Sons, New York, 1922.

†Zarathustra, *On the Gift-giving Virtue*.

MSMS Centennial Series

1930-33 Recalls Problems Caused by Depression; Joint Committee Builds Up Public Opinion

By William J. Stapleton, Jr., M.D.
MSMS Historian

Detroit, Michigan

The MSMS History through 1929 appeared in the September, October and November Journals. *This month,* The Journal *is proud to begin a series of articles by William J. Stapleton, Jr., M.D., Detroit, who is the MSMS Historian. Each month, he will trace the history of the society for several years—the series continuing until September 1965 when MSMS will celebrate its Centennial Anniversary.*

1930

One of the important accomplishments in 1930 was the publication of the two-volume "Medical History of Michigan." The man primarily responsible was C. B. Burr, M.D., of Flint, who was chairman of the MSMS Committee on Medical History. Various doctors wrote portions of the MSMS history.

Another major event of 1930 was the hosting by Michigan of the annual meeting of the American Medical Association in Detroit.

The year 1930 was a busy one. Here are some of the highlights: A cancer committee was created at the Annual Meeting of the House of Delegates, and also at this meeting a committee was appointed to study the annual registration of physicians. Doctors will note that it took over 30 years before we started to pay $5.00 a year for registration in Medicine. In the September Journal, there was a discussion re "Legal Requirements for Practice" on page 683, plus the requirements of the Michigan State Board of Registration in Medicine. We then planned a program in postgraduate medicine, which was to be carried on through the Michigan State Medical Society and the University of Michigan.



J. D. Brook, M.D.
President

It is interesting to note that in 1930, it was stated in the Journal that Michigan was primarily faced with the lack of institutional accommodations for tuberculosis. The medical profession had a problem in the removal of the source of infection. Today we have closed our hospitals for the treatment of tuberculosis because of a lack of patients.

The Journal tells about the "Major Objectives of the Michigan State Medical Society." The main objectives are the integrity and influence of the County Societies, which must be maintained. Postgraduate opportunities must be presented and the public must be educated in respect to health problems.

The MSMS postgraduate activities drew 106 doctors and dentists.

The legal requirements for practice were outlined in the September 1930 Journal as follows:

Act 237 as amended places upon the physician, who has received a license to practice in the State of Michigan, certain obligations:

1. He must file his license certificate with the county clerk of the county in which he locates. If he moves to another county, he must file a certified copy in that county.

2. A doctor's license may be revoked for the following violations:

(a) Procuring, aiding, or abetting a criminal abortion.
(b) Obtaining a fee on the assurance that an incurable disease may be permanently cured.
(c) The willfully betraying of a professional secret.
(d) All advertising in which grossly improbable statements are made.
(e) Advertising to treat a venereal disease.
(f) Obscene or offensive advertising.
(g) The secret division of fees.

The Author
WILLIAM J. STAPLETON, Jr., M.D.
MSMS Historian



(h) Giving or prescribing alcohol for other than therapeutic purposes.
(i) Offenses involving moral terpitude, habitual intemperance, or drug addiction.
(j) Criminal conviction.

The Woman's Auxiliary in 1930 had a total membership of 648. This year Oakland County joined.

In the March 1930 JOURNAL, we find "World of the Michigan State Medical Society," a fifteen point program. The Michigan State Medical Society is actively engaged in the following endeavors:

1. Joint Committee on Public Health Education
2. Representation on and cooperation with the State Crippled Children's Bureau
3. Executive Committee conferences with the State Commissioner of Health
4. Joint Activity with the Department of Postgraduate Medicine at the University
5. Participating in the investigations of the National Committee on the Cost of Medical Care
6. Representation upon the White House Conference on Infant and Child Welfare
7. Contact with Insurance Companies and formulating policies in regard to insurance reports
8. Compilation and publication of our Society's history
9. Annual Conference of County Secretaries
10. Legislation problems—State and National
11. The Annual Meeting
12. THE JOURNAL
13. Medical-Legal Defense
14. Bureau of Public Information
15. Standing Committees on Health, Tuberculosis, Civic Relations

An item of importance to industries was the problem of safely re-establishing in their service the employees who have been seriously ill or injured. Industrial physicians are now inclined to make a more careful check-up on the physical condition of such employees on their return to work. Some firms require a careful examination of certain organs if there has been an absence of three days or more. Such precautions are of great physical importance to the employee and of economic importance to the employer.

J. D. Brook, M.D., Grandville, was the MSMS President.

1931

The MSMS Annual Meeting was held in Pontiac and helped to focus attention on the 100th Anniversary of the Oakland County Medical Society.

In 1931, an outbreak in Michigan of poliomyelitis reached greater proportions than any previous outbreak of disease in the state. A Michigan Commission on Infantile Paralysis was set up with MSMS and other organizations cooperating. The first indication of an epidemic came on August 20, 1931, and within 24 hours MSMS had sent to every MSMS member a Poliomyelitis Bulletin containing a table of diagnostic symptoms. Representatives of MSMS met with the State Commissioner of Health to develop patterns for consultant services, laboratory assistance, etc. An Educational Clinic was held for MSMS members.

During 1931, there was a noted increase in MSMS public health activities. In addition to the polio activity, county health units recommended that advisory committees be appointed by component societies, and the State Tuberculosis Society requested MSMS and the University of Michigan to undertake the establishment of diagnostic clinics. MSMS vigorously opposed an antivivisection proposal in the U. S. House of Representatives . . . Wayne County Medical Society began the Beaumont Lecture Foundation . . . W. K. Kellogg established the W. K. Kellogg Foundation at Battle Creek . . . The Upper Peninsula Medical Society dealt with heart diseases, gastric surgery, gall bladder surgery and pelvic infections at its annual meeting . . . C. B. Burr, M.D., MSMS Past President and Historian, died—less than one year after publication of his "Medical History of Michigan."



R. C. STONE, M.D.
President

Also in 1931, the MSMS Cancer Commission held its first meeting and decided to make a survey of the facilities for the diagnosis and treatment of cancer in each county . . . And a proposed bill to give osteopaths all rights to practice medicine and surgery died in committee.

MSMS supported an Annual Registration of Physicians Bill, which included the following benefits:

1. The ascertaining of an authentic up-to-date list of all physicians duly authorized to practice medicine and surgery.
2. The exposing of unlicensed and illegal practitioners and a means by which the Board of Registration and the law enforcement officers of the state to institute legal action against this group.

The fee for registration will be $2.00. Failure to re-register shall not automatically cancel or revoke the basic license of the holder. Those failing to re-register shall be considered in suspension until they re-register, providing no charges are filed against the applicant.

The MSMS President was R. C. Stone, M.D., of Battle Creek.

On April 14, 1931, the Joint Session of the Michi-

gan Legislature honored the following men: Frederick Novy, M.D., Moses Gomberg, D. Sc., and Reuben L. Kahn, D. Sc.

The Department of Postgraduate Medicine at the University and the Michigan State Medical Society presented a series of courses at Receiving, Herman Keifer Hospitals; Detroit, June 15-27, 1931. The courses included Fractures, Proctology, Tuberculosis, Cardiology, Gastro-Enterology, Allergy, Mental Hygiene, Growth and Development, Serology, Roentgenology, Physical Therapy, Laboratory Technique, Metabolic and Nutritional Diseases (adults), Diseases of the Blood and Blood-Forming Organs, Gynecological Pathology (Gross and Microscopic), Infectious Diseases of Infancy and Childhood, Infant Feeding and Nutritional Diseases of Childhood.

1932

During 1932, the MSMS membership because of the depression dropped 191 members from 3,426 in January to 3,235 in December. The MSMS Council that year cut expenses and reduced the MSMS membership dues for 1932 from $10 to $7.50. The County Secretaries Conference was postponed to save funds and the Councilors held personal conferences with the secretaries of the county medical societies in their districts.

The MSMS House of Delegates held a special session in January at Jackson to hear the report of the special committee on the Survey of Medical Agencies. The following resolutions were adopted:

1. That any physician becomes ineligible for membership if he associates with any group that provides medical care to individuals who are financially able to pay for medical service and where such groups do not permit its medical staff to determine the individual's eligibility for free service.
2. That the House of Delegates transmit to the Administration Committee of the University Medical School and Hospital its disapproval of any attempt or activity that has for its purpose the taking over by medical faculty members the administration of any clinic in the state.
3. That each county society appoint a Public Relations Committee for the study, solution, and adjustment of local problems.
4. That legal proceedings be instituted against corporations now practicing corporate practice of medicine.

The House of Delegates that year also recommended eight tasks to the County Societies. They were:

1. The creation of a Public Relations Committee that shall solve and adjust local economic problems.
2. The appointment of a local medico-legal advisor who shall cooperate with the medico-legal Committee.
3. Devising a county plan for the care of indigents.
4. Securing as members every eligible physician in the county.
5. Appointment of legislative committee that will maintain intimate contact with your legislative representatives in Lansing and Washington.
6. Organization of Woman's Auxiliary.
7. Conducting Public Health Educational Meetings.
8. Apply the recommendations of our State Committees on Clinic and Industrial Relations, Cancer, and Survey of Medical Agencies.

The American Roentgen Ray Society met in Detroit and discussed diseases of the joints . . . the MSMS Annual Session drew 796 doctors to Kalamazoo . . . The Woman's Auxiliary held its annual meeting also in Kalamazoo with new units in Eaton, Kent and Ottawa Counties . . . and the Michigan X-Ray and Radium Society was organized in Detroit. The MSMS Public Relations Committee had returns from 67 of the 83 counties in its Survey of Medical Services and Health Agencies. Other activities reported in the MSMS JOURNALS in 1932 included the beginning of an annual inspection by the State Health Department of summer resorts . . . The development of Wayne County Medical Society plans to observe 1933 the 100th anniversary of the publications of the first work by Beaumont . . . And the continuing work of the Michigan Commission on Infantile Paralysis.



CARL F. MOLL, M.D.
President

The ambitious work of the Joint Committee of MSMS with other health and educational groups to build up sound public opinion relative to the questions of public and private medicine continued. Through the University of Michigan Extension Bureau, County medical and dental societies, health organizations and school officials, the Joint Committee performed the following work—public health lectures, press health columns, high school lectures, poster contests, essay contests, school instruction and press interviews.

The President for 1932 was Carl F. Moll, M.D., of Flint.

MICHIGAN DEPARTMENT OF HEALTH
ALBERT E. HEUSTIS M.D., State Health Commissioner

Sputum Specimens for Detection of Tuberculosis

In the past, the Division of Laboratories has requested a series of sputum specimens from an individual patient, either for purposes of follow-up or diagnosis. The series was pooled, treated, then cultured and injected into an animal for detection of the presence of *Mycobacterium tuberculosis*.

We now request a single 5-10 ml sample, preferably taken in early morning, in lieu of a series of specimens. An adequate single specimen, it is emphasized, is at least 5-10 ml in volume. Whether this is a cough induced sputum or delivered normally is immaterial; either type is acceptable. Because of the time factor in shipping neutralized gastric specimens to the laboratory, physicians are asked to consider the cough induced sputum as a substitute for gastric aspirates. Physicians interested in the induced cough technique are asked to contact local health departments or tuberculosis sanatoriums regarding availability of equipment.

The change in policy regarding pools of sputum has been made on the basis of U. S. Public Health Service recommendations.

Getting Together in Diabetes Control

On December 12 and 13, the Division of Adult Health will hold its tenth annual In-Service Training Program. To be held at the Jack Tar Hotel in Lansing, the meeting will feature a dinner address by Dr. Jerome Conn, Professor of Medicine, Division of Endocrinology and Metabolism, University of Michigan Medical Center, on the subject of The Search for Parameters of the Prediabetic State. All interested physicians are invited to attend this meeting which begins at 1:30 P.M., Thursday and concludes at noon on Friday.

Sodium Content of Public Water Supplies

In October, the department published a new pamphlet listing the sodium content of all public water supplies in Michigan. An attempt was made to send a copy to every physician in the state. It is hoped that this material will be of considerable value in controlling edema in persons on a strict dietary sodium restriction. If you have not received a copy of this pamphlet and would like to do so, please write to the Division of Adult Health, Michigan Department of Health, 3500 North Logan Street, Lansing 48914.

In an effort to gather further information, the department is cooperating with the Public Health Service in a two-year study of the significance of sodium in public water supplies. Seventy-nine municipal water departments in Michigan are taking part in the study along with about 3,000 other water suppliers in the nation.

The study will be used to map levels of sodium concentration in water supplies throughout the country. Although information on the sodium content of water supplies in Michigan has already been compiled by the department (as noted above), for the purposes of this survey it is desirable that a number of analyses be made at frequent intervals in a uniform manner and in one central laboratory. In addition, it is hoped that by comparing the incidence of selected disease in areas of high and low sodium concentrations, it may be possible to establish a definite relationship between the intake of sodium and the progress of certain diseases.

Representative samples from water supplies taking part in the study will be submitted once every three months to the Public Health Service's Heart Disease Control Laboratory in Atlanta, Georgia.

Control of Atmospheric Contaminants

Of interest primarily to industrial physicians but also to others is a pamphlet Basic Guides for Control of Exposure to Atmospheric Contaminants in Places of Employment. The purpose of this material is to help prevent occupational diseases by establishing basic guides in the evaluation and design of control measures applied to industrial operations and processes. Essentially, the document is a compilation of a listing of various toxic gases, vapors, dusts, fumes, mists, and mineral and nonmetallic inorganic dusts, along with a maximum allowable concentration of these contaminants based on a repeated eight-hour work day. Physicians interested in obtaining a copy of this pamphlet should write to the Division of Occupational Health, Michigan Department of Health, 3500 North Logan Street, Lansing 48914.



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MSMS Offers Speakers To GR Service Clubs

During the 1963 Annual Session in Grand Rapids, several MSMS speakers were provided for service clubs there.

Heading the list was AMA President Edward R. Annis, M.D., who spoke to the Downtown Rotary Club. MSMS President O. J. Johnson, M.D., spoke to the Optimists Club on "Challenges to Medicine," and MSMS Past President Clarence I. Owen, M.D., the Lions Club on "The Future of Medicine."

Appearing before the Exchange Club was MSMS Councilor Robert J. Mason, M.D., on "Progress in Medicine," and Michael J. Brennan, M.D., Detroit, to the Kiwanis Club on "Avoidable Causes of Cancer." Doctor Brennan appeared under the sponsorship of the Michigan Cancer Coordinating Committee.

New Insurance Commissioner

Allen L. Mayerson, professor of insurance and actuarial mathematics at the University of Michigan, is the new State Insurance Commissioner, appointed by Governor Romney. One of five insurance actuaries in Michigan, Mr. Mayerson was with the Institute of Life Insurance in New York, the National Surety Corporation in New York and the New York State Insurance Department before joining the U-M faculty in 1956.

MSMS Conducts Workshop For County Executives

Executive secretaries of component county medical societies in Michigan participated in a workshop at MSMS on November 7.

The secretaries and MSMS staff members discussed such matters as 1963 House of Delegates Actions, Preview of State Legislation, Current Major Component Society Projects, Plans for Reorganization of State Government, and The Role of the Component Society in Operation Hometown, Community Health Week, and AMA-ERF.

William R. Ramsey, American Medical Association field representative, participated in the workshop to discuss new AMA services.

County Society executives who attended were Mrs. Ruth Garnsey, Genesee County; John B. Kantner, Ingham County; William G. McClimans, Kent County; Mrs. Lucy W. Bartlett, Muskegon County; Mrs. Mary G. Haines and Miss Alberta Kazarian, both of Oakland County; and Miss Else Kolhede, Wayne County.



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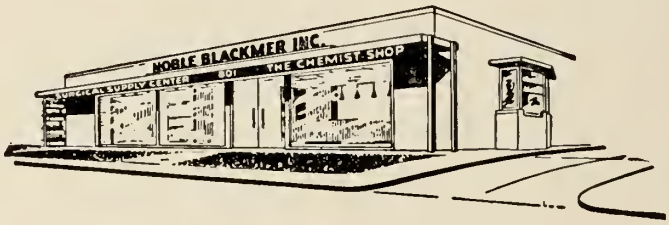
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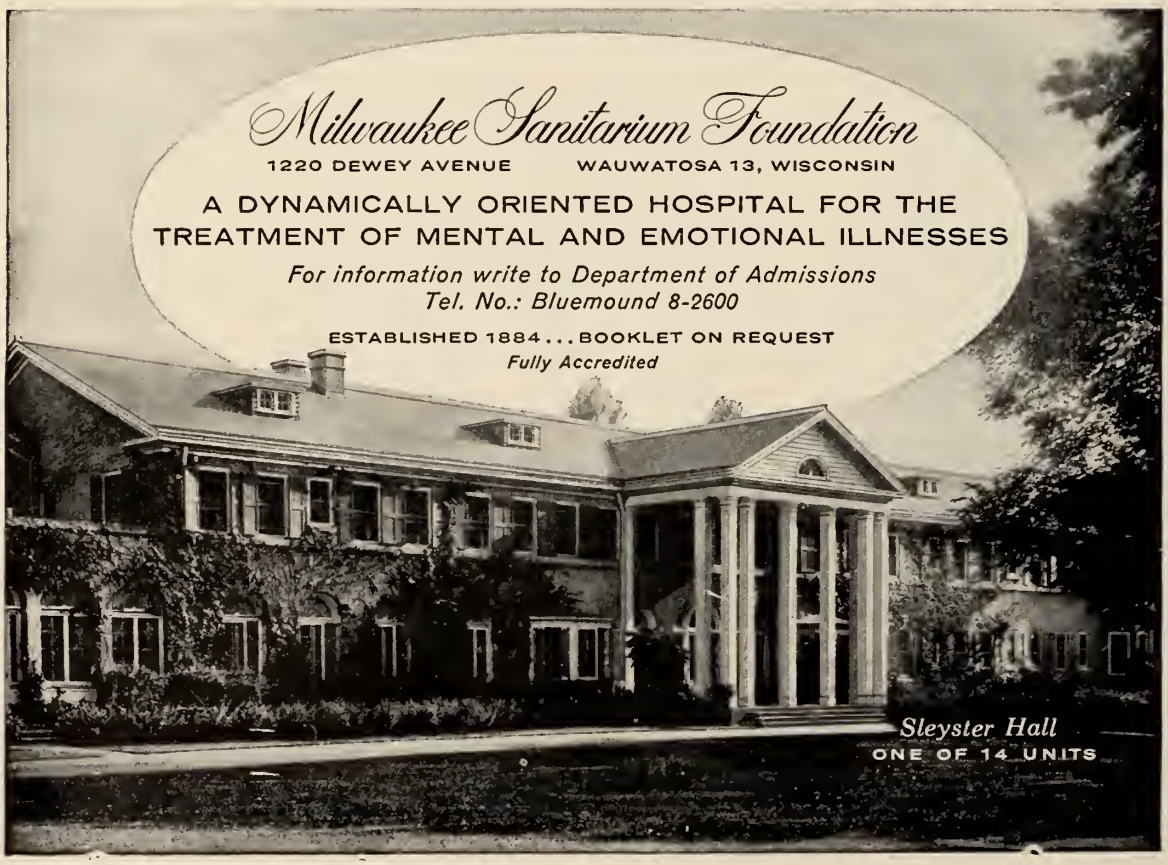


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Plan MAP Congress February 7-8, Lansing

"Money" will be the theme of the 5th annual Congress of the Professions to be held at the Jack Tar Hotel in Lansing on February 7 and 8, 1964.

O. J. Johnson, M.D., Bay City, President of the Michigan State Medical Society, will serve as Honorary Chairman of the Congress. This is the annual meeting of the American Association of the Professions and the Michigan Association.

According to Frank D. Richards, M.D., from Lansing and Chairman of the Congress Planning Committee, "The total time will not be spent on the review of how professional people can earn more money, although it is possible that that idea may be considered.

"Rather, the emphasis will be placed on where money comes from for professional education, research and practice; what effect the pressures and expenditures of money have on the practice and progress of the professions; and how the various mechanisms for paying for professional services affect distribution and delivery of such services."

Discussing topics related to the "Money" theme will be outstanding leaders of funds and foundations, financiers, and heads of governmental financial policy-making units.

Last year's Congress of the Professions drew national attention both because of its unusually high caliber program and the attendance of representatives from sixteen states.

Invited to attend and participate in the 1964 Congress are the officers and members of the Michigan State Medical Society.

Medical Convention Leaders To Confer in Detroit

The Annual Joint Conference on Medical Conventions will be held at the Sheraton-Cadillac Hotel, and Cobo Hall in Detroit, January 6-9, 1964.

Sponsored by the Professional Convention Management Association and the Medical Exhibitors Association, the conference will offer to executive secretaries and exhibit managers in medical and allied fields many hints on how better to organize their annual convention in all its aspects.

In addition to the association and industry groups sponsoring the meeting, it is expected that representatives of convention bureaus, hotels, and service organizations will attend since these individuals are so intimately connected with the activities to be discussed.

Two Michigan doctors will appear on the program. Max L. Lichter, M.D., Melvindale, will be a panelist on "Doctors' Ratings



of Exhibits" and Homer H. Stryker, M.D., Kalamazoo, will present the annual banquet address.

Also appearing on the program will be Clyde T. Hardwick, MSMS socio-economic consultant, and Herbert A. Auer, MSMS JOURNAL managing editor.

Warren F. Tryloff, MSMS associate executive director, is general chairman of arrangements for the Detroit meeting. Wm. J. Burns, MSMS Executive Director, is president of the Professional Convention Management Association.

List U-M Postgraduate Courses for Early '64

The following courses are scheduled for early 1964 by the U-M Department of Postgraduate Medicine. A more detailed description of these courses will be mailed upon request sent to John M. Sheldon, M.D., W5610 University Hospital, Ann Arbor, Michigan.

Intermittent courses: Anatomy (Thursday afternoons) January 23-May 7; Psychiatry for Internists (Wednesday afternoons) February 19-May 6; and Selected Clinical Topics (Tuesday evenings) January 21-April 28.

Continuous courses: Allergy March 30-April 1; Diseases of the Blood January 27-31; Diseases of the Heart February 3-7; Electrocardiographic Diagnosis March 16-20; Endocrinology and Metabolism April 13-17; Infertility and Endocrinology March 5-6; Neurology, Clinical March 2-3; Obstetrics and Gynecology January 22-24; Ophthalmology Conference April 20-22; Otorhinolaryngology Conference April 16-18; Pediatrics January 20-22; Pediatric Neurology February 13-15; Psychiatry February 17-18; Pulmonary Diseases April 6-8; Radiology, Diagnostic March 30-April 1; Radioactive Isotopes, Clinical Use of (As arranged); Rheumatology February 26-28; Recent Advances in Therapeutics April 27-May 1.

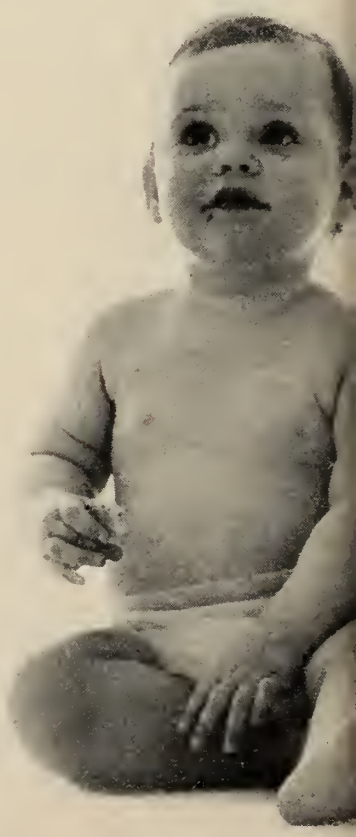
Courses in Basic Sciences and their clinical correlation and application: Endocrinology January 6-10; Physiology January 13-17; Pharmacology February 10-14; Anatomy (Obstetrics and Gynecology) February 3-14; Anatomy (Surgery) April 20-May 29; Pathology (Obstetrics and Gynecology) February 17-18.

Elect Ann Arbor Doctor

Tommy N. Evans, M.D., Ann Arbor, is the new Vice Chairman of District V of the American College of Obstetricians and Gynecologists. Doctor Evans was chosen at the recent district meeting held at the Statler-Hilton Hotel in Detroit.

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Offer Teaching Aid

A new audio-visual teaching aid available from the Michigan Heart Association to physicians is "The Causes of Secondary Hypertension with Special Reference to Renovascular Disease and Surgical Treatment." This is a 40-minute taped lecture; speed—3¾ IPS, and is accompanied by 31 slides, 35 mm., compiled by Sibley W. Hoobler, M.D., James Conway, M.D., and Bruce Stewart, M.D., of the Hypertension Unit, University of Michigan Medical Center. For reservations, call or write the Michigan Heart Association, 13100 Puritan, Detroit 27.

Elect M.D.'s to Board Of State TB Association

During the recent meeting of the Michigan Tuberculosis and Respiratory Disease Association three Michigan physicians were elected to the board of trustees. Named were Louis F. Hayes, M.D., Gaylord; Arthur W. Strom, M.D., Hillsdale, and Irwin C. Sweet, M.D., Gladwin.

Officers re-elected were Lloyd Humbarger, Battle Creek attorney, president; Paul H. Chapman, M.D., Detroit, first vice-president; Circuit Judge Alton H. Noe, Mt. Clemens, second vice-president; Miss Julia McNeal, Midland, secretary; and John R. Pettibone, Lansing, treasurer.

A highlight of the joint meeting was the presentation of the "Bruce H. Douglas Award" for outstanding service in the field of thoracic surgery to Robert R. Shaw, M.D., of Texas. Doctor Shaw, a graduate of the University of Michigan, was cited for his pioneering work in surgical treatment for tuberculosis victims and his recent work in Kabul, Afghanistan.

Commission on Aging Names Task Forces

The Michigan Commission on Aging has appointed several task forces to develop plans for the coming 10 years.

MSMS members named to the Health Task Force were John B. Bryan, M.D., Detroit; W. B. Prothro, M.D., Grand Rapids; A. Hazen Price, M.D., Detroit; V. K. Volk, M.D., Saginaw; V. A. Getting, M.D., Ann Arbor; and John B. Cowan, M.D., Lansing. Named to the Welfare Task Force was M. E. Ellis, M.D., Grand Rapids. Named to the Mental Health Task Force were M. R. Kinde, M.D., Battle Creek; Benjamin Jeffries,



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M.D., Detroit; A. P. Dukay, M.D., Ypsilanti; Myroslaw Hrushka, M.D., Pontiac; and A. H. Hirschfeld, M.D., Detroit.

MCCC Exhibit Popular



One of the scientific exhibits at the 1963 MSMS Annual Session which attracted much attention was that of the Michigan Cancer Coordinating Committee, which includes MSMS as a participating organization. Here, W. L. Schwarz, M.D., and his wife, of Onekama, get an explanation about the MCCC's professional education activities from Bernard E. Luck, D.D.S., Lansing, MCCC Chairman.

Wayne State Begins Seminar in Psychiatry

Twenty-five doctors are enrolled in a "Postgraduate Seminar in Psychiatry" this winter at Lafayette Clinic, Detroit. The seminar is sponsored and staffed by faculty from the Wayne State University College of Medicine's department of psychiatry and the Lafayette Clinic. Co-sponsor is the Michigan Academy of General Practice. Beginning date for the program was December 19, and it will continue through April.

A National Institute of Mental Health grant covers tuition for all doctors taking the course. Leading the faculty for the course is Jacques S. Gottlieb, M.D., chairman of the department of psychiatry.

To Direct State Commission

R. Gerald Rice, M.D., former director of the Pennsylvania Maternal and Child Health and Crippled Children Services, will begin duties in January as the new director of the Michigan Crippled Children Commission. The former director, Carleton Dean, M.D., died in December, 1961.

Legislature to Face Busy '64 Session

By Morris A. Riley
MSMS Legislative Representative

The Michigan State Legislature, which labored through the Fall in a special session confined to "tax reform" and legislation required by the new State Constitution, returns to Lansing in mid-January for its regular meeting.

If the form book is followed, approximately 1,500 proposals on every subject from "Absent voters—ballots" to "Zoning—Townships" will come before the lawmakers, who also face the Herculean task of fully implementing the new Constitution, which takes effect on January 1.

* * *

OF PARTICULAR INTEREST to Medicine will be the activities of a special joint House-Senate Committee, responsible for considering ways and means of consolidating the State's agencies, boards and commissions into 20 "principal departments."

Generally, 50 or more of the proposed laws in each legislative session are directly related to the practice of medicine and require a line-by-line analysis by the MSMS Legal Affairs Committee. Over 100 additional bills will be of some interest to Medicine.

Legislation was introduced with partial success by MSMS in 1963 to up-date the 16-year-old fee schedules applied by the Michigan Crippled Children Commission, and will be reintroduced in 1964. The presence of a huge state deficit made impossible the adoption of a more realistic schedule in 1963.

Legislation will also be introduced by MSMS in 1964, at the direction of the House of Delegates, to create a "State Medical Disciplinary Board." Research is now under way preparatory to the drafting of the proposal.

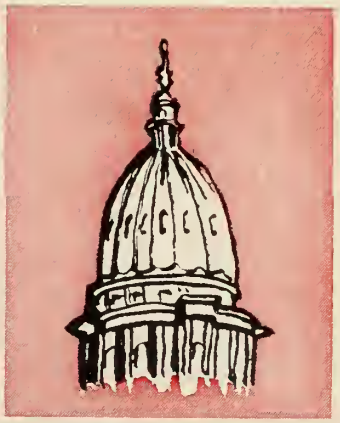
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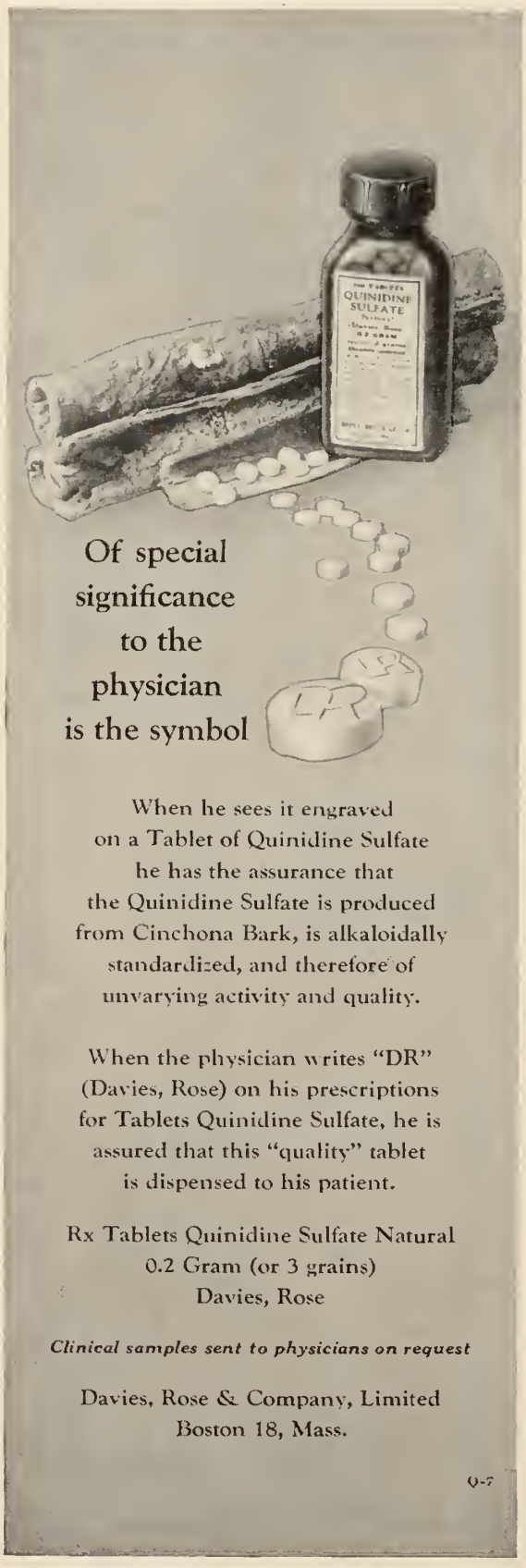
AMONG THE MANY health proposals known to be "in the wings" for 1964 introduction are the Interstate Mental Health Compact, a bill to permit creation of health insurance "pooling" plans, and a bill calling for compulsory motor vehicle inspection and repair.

Other proposals expected to be brought before the lawmakers include one to designate paragoric as an exempt narcotic, a proposal designed to deal with cancer "quacks," a bill dealing with provisions for determining degree of intoxication of drivers, selective amendments to the 1963 community mental health law, a proposal to license physical therapists, a bill to liberalize the use of nursing homes in the M.A.A. program, and an amendment to the existing law pertaining to the power of the State Health Commissioner to designate medical research projects. A bill requiring a vote before a city can fluoridate its water supply may again be introduced.

* * *

THESE AND MANY additional bills, if and when introduced, will be thoroughly reviewed by the widely-representative, 33-member MSMS Legal Affairs Committee. As in past years, "Legislative Re-





ports" will be issued regularly to hundreds of physicians who have been designated by their county societies to keep abreast of Capitol developments. Any MSMS member wishing to receive these "Reports" should arrange to do so through his County Medical Society.

Polls by Congressmen Oppose King-Anderson

Polls continue to reveal strong opposition to legislation that would provide hospitalization for the aged under the Social Security system.

Twenty-four polls by Congressmen of both parties this year posed the controversial issue and only two showed a majority favored the plan.

A total of 211,666 individual responses were included in a tabulation of 19 to the polls, with 134,973 individuals opposed to the use of the Social Security mechanism, 58,121 favoring it, and 18,572 with no opinion. This tabulation shows that 63.8 per cent of those responding opposed the use of the Social Security mechanism, 24.7 per cent favored it and 8.8 per cent had no opinion.

Percentages tabulated last year near the close of the 87th Congress were 54.4 per cent in opposition, 39.2 per cent favored it and 6.4 per cent had no opinion.

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Members Appointed To State Boards

Several MSMS members were recently appointed by Governor Romney to Michigan's new Mental Health Advisory Council. Those named include Benjamin Jeffries, M.D., Detroit, chairman of the MSMS Mental Health Committee; Kenneth R. Magee, M.D., Ann Arbor; Peter A. Martin, M.D., consultant to Governor Romney on Mental Health; Gelmer A. Van Noord, M.D., Grand Rapids. Doctor Martin will serve as chairman of the Council.

The Senate has approved the appointment of two MSMS members to the Civil Defense Advisory Council. Appointed by Governor Romney were Albert E. Heustis, M.D., State Health Commissioner, and Grant L. Otis, M.D., Jackson, Chairman of the MSMS Disaster Medical Care Committee.

CITED—Two MSMS members have been cited by the U. S. Civil Defense Council for their contributions to medical, health and disaster preparedness. Honored at the Council's national conference recently were Albert E. Heustis, M.D., Michigan State Health Commissioner, and Carl J. Sprunk, M.D., Detroit, a special consultant for the U. S. Division of Health Mobilization.

HONORED—Ralph Ten Have, M.D., Ottawa County Health Department director, has been cited as "Health Officer of the Year" by the Michigan Health Officers Association. The MHOA Award was presented at Grand Haven recently by Robert E. Rowe, M.D., Port Huron, MHOA president. Doctor Ten Have has served Ottawa County for 32 years.

CHAMBER PRESIDENT—Sidney E. Chapin, M.D., Dearborn, is the busy president of the Dearborn Chamber of Commerce, installed at the recent annual meeting. He has a long record of service to the community and to many Chamber efforts.

SPEAKER—Jean Lukens, M.D., Pontiac, spoke about "An Experiment Plan in Action" (the Perceptual Development Program of the Oakland County Schools) to the National Society for Crippled Children and Adult's "Symposium on Children with Minimal Brain Injury" in Chicago in November.

CITED—Irwin C. Sweet, M.D., health officer for Clare, Gladwin and Arenac Counties, recently received a Distinguished Service Award from the Michigan Health Officers Association. Robert Rowe, M.D., Port Huron, MHOA president, made the presentation.

VISITING LECTURES—The Northville State Hospital reports the following visiting lectures for January: January 7, 2 p.m., "Remarks Concerning the Personality of Michelangelo Buonarroti," by Richard F. Sterba, M.D., Wayne State University; and January 11, 2 p.m., "Advances in Experimental Psychiatry," by Jules H. Masserman, M.D., Northwestern University.



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SPEAKER—Samuel J. Levin, M.D., Detroit, recently read a paper before the Allergy Section of the American Academy of Pediatrics in Chicago about "Treatment of Allergic Diseases in Children by Repository Antigens," and another paper before the Midwest Forum on Allergy in Cleveland about "Allergic Tracheitis."

ON GUEST FACULTY—Two MSMS members will be on the "guest faculty" for the "Symposium on Scintiscanning in Clinical Medicine" at the Bowman Gray School of Medicine, Winston-Salem, N. C., on January 30-31. They are William H. Beierwaltes, M.D., and Edward A. Carr, Jr., M.D., both of Ann Arbor.

PRESENTS PAPERS—M. K. Newman, M.D., Detroit, recently presented a paper on "Laboratory Procedures—Serum Enzyme Studies in Muscle Disease; and Clinical Problems in Myogenic and Neurogenic Diseases" before a seminar at Ohio State University College of Medicine, and also a paper on "Cross Examination Strategy and Techniques, Physical Medicine Specialist" at the Practicing Law Institute in New York City.

IN PERU—Russell N. DeJong, M.D., Ann Arbor, took part in the First Pan American Neurological Congress in Lima, Peru. Dr. DeJong, a vice-president of the Congress, was in charge of a symposium on "Neurological Manifestations of Disorders of the Reticuloendothelial System."

APPOINTED—Winthrop N. Davey, M.D., Ann Arbor, has been appointed by U. S. Surgeon General Dr. Luther T. Terry to serve on a task force to consider the problems of tuberculosis in the United States. The group was appointed because of growing concern about the degree of effectiveness of the nation's tuberculosis control efforts.

CHAIRMAN—Michael J. Brennan, M.D., Detroit, was chairman for the annual meeting of the National Federation of the Catholic Physicians Guild on "The Church, The Physician and the Population Expansion," held recently in Detroit.

HOME CARE—Participating in the recent University of Michigan Training Conference on Organized Home Care were: Miriam I. Daly, M.D., Albion; Roy J. Gerard, M.D., Saginaw, and Leslie F. Harcus, director of the Home Care program for the Michigan Health Council.

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Medical Meetings USA

JANUARY

American Academy of Orthopaedic Surgeons, Palmer House, Chicago, January 18-23. Exec. Sec.: John K. Hart, 29 E. Madison, Chicago 2.

FEBRUARY

Canadian-American Medical and Dental Ski Association, Harbor Highlands, Harbor Springs, Feb. 17-19. Sec.-Treas.: T. J. Trapasso, M.D., 916 Ashmun St., Sault Ste. Marie, Michigan.

APRIL

American Academy of General Practice, Convention Hall, Atlantic City, N. J., April 11-16. Exec. Dir.: Mac F. Cahal, JD, Volker Boulevard at Brookside, Kansas City 12, Mo.

American Association of Pathologists and Bacteriologists, Drake Hotel, Chicago, April 3-5. Sec.-Treas.: John R. Carter, M.D., University of Kansas Medical Center, Kansas City 3.

American Association of Railway Surgeons, Drake Hotel, Chicago, April 8-10. Exec. Sec.: Carl Y. Werelius, M.D., 5800 Stony Island, Chicago 37.

American College of Physicians, Chalfonte-Hadden Hall, Atlantic City N. J., April 6-10. Exec. Dir.: Edward C. Rosenow, Jr., M.D., 4200 Pine St., Philadelphia 4.

American Society of Internal Medicine, Atlantic City, N. J., April 3-5, Exec. Dir.: Albert V. Whitehall, 3410 Geary Blvd., San Francisco 18.

Industrial Medical Association, Pittsburgh-Hilton Hotel, Pittsburgh, April 13-16. Managing Dir.: Clark D. Bridges, 55 E. Washington, Chicago 2.

Ohio State Medical Association, Columbus Plaza Hotel, Columbus, April 26-30. Exec. Sec.: Charles S. Nelson, 79 E. State St., Room 1005, Columbus 15.

MAY

Aerospace Medical Association, Americana Hotel, Bal Harbour, Fla., May 11-14, Sec.: William J. Hennard, M.D., Washington National Airport, Washington 1, D. C.

American College of Obstetricians and Gynecologists, Americana Hotel, Bal Harbour, Fla., May 17-22. Exec. Dir.: Donald F. Richardson, 79 W. Monroe, Chicago 3.

American Gynecological Society, Homestead Hot Springs, Va., May 25-27. Sec.: C. J. Lund, M.D., 260 Crittendon Blvd., Rochester 20, N. Y.

American Ophthalmological Society, Homestead Hotel, Hot Springs, Va., May 28-30. Sec.: Joseph A. C. Wadsworth, M.D., 108 E. 68th St., New York 21.

American Proctologic Society Bellevue-Stratford Hotel, Philadelphia, May 10-14, Sec.: Norman D. Nigro, M.D., 320 W. Lafayette, Detroit 26.

Call Attention to January Article on Pension Plans

The Michigan State Medical Society consultants on pension plans for physicians (HR-10, Keogh Bill) will report on plans for Michigan doctors in the January issue of THE JOURNAL. The consultants recommend that interested physicians in Michigan await until this report is made to the membership before planning future pension commitments.



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